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COUNTY COUNCIL OF ESSEX
EDUCATION COMMITTEE

LONDON SCHOOL
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ANNUAL REPORT

OF THE

Principal School Medical Officer

FOR THE YEAR

1955

COUNTY COUNCIL OF ESSEX
EDUCATION COMMITTEE

ANNUAL REPORT

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Principal School Medical Officer

FOR THE YEAR

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INDEX

Page

- Audiometry 35, 70

- B.C.G. Vaccination 4, 22
- Blind and Partially Sighted Children 48

- Cardiac Clinics 40
- Cerebral Palsy Unit 4, 55
- Child Guidance 41, 64, 72
- Chiropody Service 4, 26
- Colour Vision Testing 4, 33

- Deaf and Partially Deaf Children 35, 49, 70, 71
- Delicate Children 56
- Dental Service 58, 65
- Diphtheria 25, 69

- Ear, Nose and Throat Diseases 29, 34, 62, 64
- Educationally Sub-Normal Children 50
- Enuresis Clinic 41
- Epileptic Children 57

- Food Poisoning, outbreak of 19
- Foot Defects 4, 25, 69
- Handicapped Children 47, 73

- Health :
  - Education 15
  - Services Clinics 35
- Hearing of School Children 35, 49, 70, 71

- Maladjusted Children 52
- Meals Service, School 18
- Medical :
  - Inspection 12, 61, 67
  - Record Cards 13
  - Treatment 29, 61
- Minor Ailment Clinics 74

- Nurses, School 15

Page

- Orthodontic Treatment 59
- Orthopædic Defects 39, 62, 64
- Orthoptic Treatment 32
- Otitis Media 35
- Overseas Visitors 46

- Pædiatric Clinic 41
- Physical Education 17
- Physically Handicapped Children 55
- Population, School 12, 67
- Preface 4

- Rheumatism Clinic 40

- School :
  - Children, General Condition of 13, 63
  - Meals Service 18
  - Nurse, Work of 15
  - Population 12, 67
  - Premises 17
  - Psychological Service 41, 64, 72

- Skin Diseases 29, 30, 62, 63, 69
- Spastics 4, 55
- Special :
  - Educational Treatment 47
  - Schools 47
  - Services Sub-Committee 3
- Speech Defects 29, 36, 57, 62, 64, 71
- Staff 4, 6, 58
- Statistical Tables 61

- Treatment 29, 61
- Tuberculosis 19

- Uncleanliness 16, 63, 67, 68

- Visual Defects 16, 29, 30, 62, 64

- X-Ray Examinations 21, 68

THE SPECIAL SERVICES SUB-COMMITTEE OF THE EDUCATION COMMITTEE—1955

Cann, Rev. B. C.

*Chaplin, G. F.

Cleall, Rev. Canon A. V. G.

Curtis, G. H. L.

Davies, W. H.

Fallaize, Mrs. L.

*Foster, Sir Frank S.

Gofton, J. W.

Green, H. L.

Hardy, E. C.

*Hollis, Mrs. E. F. M.

Law, Mrs. E. G.

Littlejohn, Mrs. R. C.

Mathews, J. W.

Meyrick, D. T.

Ogier, L. L. (resigned 14.7.55)

Olsen, Mrs. E. Ström

Pawson, J. C.

Powell, P. S.

Prendergast, Mrs. A. E.

Riley, Q. T. P. M.

Roberts, Mrs. O. M. J.

Rose, G. E.

Sargent, Mrs. D. M.

Sibley, W. A.

Spray, Mrs. D. C. P.

Vaizey, Brig. J. T. de H.

Walker, Miss A. I.

Walsh, J. J.

*Young, Major A. M.

**Ex-officio* members.

PREFACE

County Hall,
Chelmsford.
June, 1956.

To the Chairman and Members of the Education Committee.

Sir, Ladies and Gentlemen,

I have the honour to present the report of the Principal School Medical Officer for the year 1955 which covers the first full year of my duties as your Principal School Medical Officer.

It will be recalled that last year special reference was made to the scheme for the B.C.G. (Bacillus-Calmette-Guerin) vaccination of school children in their fourteenth year and it will be noted from the references on page 22 the scheme got well under way during 1955. The very satisfactory acceptance rate of 50.4% throughout the County is to no small extent attributable to the excellent support given to the scheme by Head Teachers of Secondary Schools.

A full year's experience of the experiment in South Essex Division to ascertain the extent of the Chiropodist's role in the prevention of foot defects among school children is now available. A detailed review of it is included in the report. Whilst the value of the experiment cannot possibly be assessed on the basis of one year's work nor indeed until follow-up enquiries have shown whether the treatment given to the children at present at school prevents their incapacity in later life, it has been felt advisable to extend the services of the part-time Chiropodist engaged in this experiment for another year from 1st January, 1956.

Mention is made of the opening of the Cerebral Palsy Unit at Ilford in May, 1955, and it is interesting to note that the Minister of Education in his Circular 300, dated 23rd March, 1956, has now appealed to Local Education Authorities to consider the establishment of small day units for the treatment and education of the more seriously handicapped children suffering from this disease whose educability appears doubtful. This is precisely the function of the new unit at Ilford.

Attention is also drawn to the need for the colour vision testing of older pupils, particularly boys, and following the investigations referred to, the appropriate provision is being made.

During the year there have been a number of changes in the staff of the Health Department. Dr. J. A. C. Franklin came from Gloucestershire as Deputy Principal School Medical Officer on 14th March, 1955 ; Mr. J. Byrom came from Manchester to take up duty as Principal School Dental Officer on 6th June, 1955, and Dr. T. K. Whitmore joined the staff from the Home Office

(Children's Section) on 15th August, 1955, as Senior Medical Officer for Child Health in place of Dr. J. L. Miller Wood. Dr. Miller Wood had held this post since May, 1948, and I should like to record a word of thanks to him for the very able manner in which he assisted my predecessor and me in this very important section of the Department's work.

As usual I have reason to be very grateful for the support which I have received from Members of the Committee and for the continued loyalty of the whole of the staff of the School Health Service.

I have the honour to be,

Your obedient Servant,

Geo. G. Stewart

Principal School Medical Officer.

STAFF

31st December, 1955

CENTRAL OFFICE

Principal School Medical Officer:

George G. Stewart, M.R.C.S., L.R.C.P., D.P.H.

Deputy Principal School Medical Officer:

J. A. C. Franklin, M.B., B.S., D.P.H.
(Commenced 14.3.55)

Senior Medical Officer (Child Health):

T. K. Whitmore, M.R.C.S., L.R.C.P., D.C.H.
(Commenced 15.8.55)

Principal School Dental Officer:

J. Byrom, L.D.S.
(Commenced 6.6.55)

DIVISIONAL STAFFS

NORTH EAST ESSEX EDUCATIONAL DIVISION

Medical Officers:

Divisional School Medical Officers:

*John D. Kershaw, M.D., B.S., D.P.H.

School Medical Officers:

Ann B. Clark, M.R.C.S., L.R.C.P.

*B. A. Hargreaves, M.R.C.S., L.R.C.P., D.P.H.
(Commenced 1.12.55)

*J. R. Hetherington, L.R.C.P. & S., L.R.F.P.S., D.P.H.

Sylvia I. E. Macmillan, M.B., B.S., D.P.H.

*R. D. Pearce, M.R.C.S., L.R.C.P., D.P.H.
(Commenced 1.1.56)

*J. S. Ranson, M.R.C.S., L.R.C.P., D.P.H.

Eleanor M. Singer, M.Sc., M.R.C.S., L.R.C.P., D.C.H.

In addition there are two Medical Officers undertaking three sessions a week on a sessional basis.

Dental Officers:

R. A. Tran, L.D.S.

*J. F. Godfrey, L.D.S.

In addition there are three Dental Officers undertaking 11 sessions a week on a sessional basis.

* Part-time Officer

MID-ESSEX EDUCATIONAL DIVISION

Medical Officers :

Divisional School Medical Officer:

*J. L. Miller Wood, M.R.C.S., L.R.C.P., D.P.H.

School Medical Officers:

*T. D. Blott, B.Sc., M.B., D.P.H.

Joyce W. Brown, M.B., Ch.B., D.P.H.

Deirdre R. Dooley, L.R.C.P. & S., D.P.H.

* Irene M. Conway Hastilow, M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H., D.C.H., D.Obst., R.C.O.G.

Muriel Parkes, B.A., M.B., B.Ch., B.A.O.

*C. R. C. Rainsford, M.D., D.P.H., D.T.M.
(Commenced 23.5.55)

Annette Wyatt, M.D., B.S., M.R.C.S., L.R.C.P.

Margaret Turner, M.R.C.S., L.R.C.P.

Dental Officers :

B. G. Brown, L.D.S.

A. M. Hughes, L.D.S., M.R.C.S., L.R.C.P.

Mrs. N. S. Mezits, Dental Doctor, Latvia.

In addition there are two Dental Officers undertaking nine sessions a week on a sessional basis.

SOUTH-EAST ESSEX EDUCATIONAL DIVISION

Medical Officers :

Divisional School Medical Officer:

*W. J. Moffat, M.B., Ch.B., D.P.H.

School Medical Officers:

Jean Buchanan, M.B., Ch.B.

*J. C. T. Fiddes, M.B., Ch.B.

T. H. J. Hargreaves, M.R.C.S., L.R.C.P.

*N. S. R. Lorraine, M.D., Ch.B., D.P.H.

*P. X. O'Dwyer, M.B., B.Ch., D.P.H.

J. Reach, M.D. (Prague).

Jean Troughton, L.R.C.P. & S.

Dental Officers :

H. J. Cracknell, L.D.S.

H. Levison, B.D.S., L.D.S.

R. Maxwell, L.D.S.

H. L. Thorn, L.D.S.

In addition there are five Dental Officers undertaking 12 sessions per week on a sessional basis.

* Part-time Officer

SOUTH ESSEX EDUCATIONAL DIVISION

Medical Officers :

Divisional School Medical Officer:

W. T. G. Boul, *M.B.E.*, M.D., D.P.H., F.Z.S.

School Medical Officers:

Ursula M. Anderson, M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.
A. R. Forbes, M.B., Ch.B., D.P.H.
Elizabeth M. Hargreaves, M.B., Ch.B., D.P.H.
R. G. Hendry, M.B., Ch.B., D.Obst.R.C.O.G., D.P.H.
Mary M. E. Rutter, M.R.C.S., L.R.C.P., M.B., B.S., D.C.H., M.D., D.P.H.
Aniela A. Szwede, M.B., Ch.B.
Doris E. C. Walker, M.B., B.S., L.R.C.P., M.R.C.S., D.A.
*S. R. Warren, M.B., Ch.B., D.P.H.
(Commenced 1.6.55)
Mair E. Williams, M.R.C.S., L.R.C.P.

Dental Officers :

R. A. Collins, L.D.S.
Mrs. C. Grieshaber, Doctor Medicinal Dentium, Berlin University.
Mrs. O. Saunders, Diploma of Dental Surgery, Latvia.

In addition there are three Dental Officers undertaking six sessions a week on a sessional basis.

FOREST EDUCATIONAL DIVISION

Medical Officers :

Divisional School Medical Officer:

F. G. Brown, *T.D.*, M.B., B.Ch., B.A.O., D.P.H.

School Medical Officers:

*J. H. Crosby, M.B., Ch.B., D.P.H.
Gisella Eisner, M.D. (Prague), D.C.H.
E. L. Ewan, M.B., Ch.B., B.Hy., D.P.H.
*H. Franks, M.B., B.S., B.Hy., D.P.H.

In addition there are two Medical Officers undertaking five sessions a week on a sessional basis.

Dental Officers:

Mrs. L. E. Broadbent, L.D.S.
Mrs. E. Kimelman, M.D. (Vienna).
C. S. Neame, L.D.S.

In addition there are five Dental Officers undertaking 12 sessions a week on a sessional basis.

* Part-time Officer

ROMFORD EDUCATIONAL DIVISION

Medical Officers :

Divisional School Medical Officer:

*James B. Samson, M.D., Ch.B., D.P.H.

School Medical Officers:

Freda M. E. Buchanan, B.A., M.B., B.Ch., B.A.O., D.A.
J. J. Duffy, M.B., B.Ch., B.A.O., D.P.H.
R. C. Greenberg, M.B., B.S., D.P.H.
Elizabeth M. Haga, M.B., B.S., L.R.C.P., D.P.H.

Dental Officers :

Miss M. L. Ell, L.D.S.
Mrs. D. Shirlaw, L.D.S.

BARKING EDUCATIONAL DIVISION

Medical Officers :

Divisional School Medical Officer:

*F. L. Groarke, M.B., L.M., D.C.H., D.P.H.
(Commenced 1.10.55)

School Medical Officers:

*Margaret I. Adamson, M.B., Ch.B., D.P.H.
Eileen E. Martin, M.B., Ch.B.
Eugenia Popper, M.D. (Vienna).
A. E. Seligmann, M.D. (Leipzig), D.T.M. & H.
Violet Spiller, M.D. (Geneva), M.R.C.S., L.R.C.P., D.P.H.
Mary H. Westlake, M.B., Ch.B., D.P.H.

Dental Officers :

A. R. Levy, L.D.S.
H. H. Cooke, L.D.S.
J. Buntin, L.D.S.
Miss Margaret M. Murray, B.D.S. (N.U.I.).
Miss Alice O. Joyce, B.D.S. (N.U.I.).

In addition there are two Dental Officers undertaking seven sessions a week on a sessional basis.

DAGENHAM EDUCATIONAL DIVISION

Medical Officers :

Divisional School Medical Officer:

*J. Adrian Gillet, M.B., Ch.B., D.P.H.
(Commenced 1.9.55)

* Part-time Officer

School Medical Officers:

CATHERINE FITZPATRICK, M.B., B.Ch.

FANNIE HIRST, M.B., Ch.B., D.P.H.

WILHELMINA C. MAGUIRE, L.M., L.R.C.P., L.R.C.S.I.

MADELINE WEIZMANN, M.R.C.S., L.R.C.P.

In addition there is one Medical Officer undertaking one session each week on a sessional basis.

Dental Officers:

There are five Dental Officers undertaking 17 sessions a week on a sessional basis.

ILFORD EDUCATIONAL DIVISION

Medical Officers:

Divisional School Medical Officer:

*I. GORDON, M.D., Ch.B., M.R.C.P., D.P.H.

School Medical Officers:

*DESIREE M. B. GROSS, M.D., Ch.B., M.M.S.A., D.P.H.

ANNIE COLLINS, M.B., B.Ch., B.A.O.

FRANCES E. O'CONNOR, B.A., M.B., B.Ch., B.A.O., D.P.H., L.M.

HELEN B. GRANGE, M.B., B.S.

JOAN M. POOLEY, M.B., B.S., D.C.H.

R. M. NOORDIN, M.R.C.S., L.R.C.P.

Dental Officers:

Senior Dental Officer:

E. V. HAIGH, L.D.S.

In addition there are 10 Dental Officers undertaking 28 sessions a week on a sessional basis.

LEYTON EDUCATIONAL DIVISION

Medical Officers:

Divisional School Medical Officer:

*M. WATKINS, M.R.C.S., L.R.C.P., D.P.H.
(Commenced 1.8.55)

School Medical Officers:

ETHEL R. EMSLIE, M.D., Ch.B., D.P.H., D.C.H.

*MARY L. GILCHRIST, M.D., Ch.B., D.P.H.

S. C. LOVELL, M.R.C.S., L.R.C.P.

ELSIE L. PEET, M.D., M.B.

In addition there is one Medical Officer undertaking two sessions a week on a sessional basis.

* Part-time Officer

Dental Officers :

Senior Dental Officer :

A. E. Hall, L.D.S.

and nine Dental Officers undertaking 23 sessions a week on a sessional basis.

WALTHAMSTOW EDUCATIONAL DIVISION

Medical Officers :

Divisional School Medical Officer :

*A. T. W. Powell, M.C., M.B., B.S., D.P.H.

School Medical Officers :

*Geoffrey Poole, M.B., B.S., D.Obst.R.C.O.G., D.P.H.
(Commenced 1.12.55)

*Marjorie Bell, M.B., B.S., D.C.H.

Roshan Bulsara, M.D., M.S., M.R.C.O.G.

*Joycelyn H. Newman, M.B., Ch.B., D.Obst.R.C.O.G., D.P.H.

Dental Officers :

Senior Dental Officer :

L. W. Elmer, L.D.S.

Dental Officers :

Miss D. Anklesaria, L.D.S.

R. E. Hyman, L.D.S.

P. Pearce, B.D.S.

G. P. L. Taylor, L.D.S.

J. Timmis, L.D.S.

In addition there is one Dental Officer undertaking three sessions a week on a sessional basis.

* Part-time Officer

School Nursing Staff and Dental Attendants

		Aggregate of time given to School Health Service work in terms of whole-time officers
Health Visitor/School Nurses	227	96.02
School Nurses only	43	
Nursing Assistants	29	11.80
Dental Attendants	51	41.87

COUNTY COUNCIL OF ESSEX EDUCATION COMMITTEE

ANNUAL REPORT
# of the
PRINCIPAL SCHOOL MEDICAL OFFICER
for the year 1955

The work of the School Health Service may be broadly considered under three main headings :

(a) Assessment of health.

(b) Promotion of good health and prevention of ill-health.

(c) Early ascertainment of conditions which are or may become a cause of ill-health or which constitute a handicap, and the provision of appropriate medical or special educational treatment.

A. ASSESSMENT OF HEALTH

1. School Population.

There has been a further increase of 9,631 children in the school population which has now reached 261,620. For the first time since 1949 the increase in the number of children in secondary schools is more than that in the primary schools. Table 1 gives the number of pupils and the number of schools for 1955 compared with those for 1954. (See Appendix A).

2. Medical Inspection.

The school medical inspection is the starting point of the work of the school medical officer and it will always be of unique importance.

Routine periodic medical inspections have again been carried out at the following periods :

(i) Soon after entry to school at the age of five years ;

(ii) Between the ages of 10 and 12 years ;

(iii) During the last year at school at the age of 14.

The inspections are mostly made at the schools but where this is not possible, owing for example to the large number of pupils accommodated in some schools, they are undertaken at nearby Health Services Clinics. The school nurse usually visits the school shortly before the medical examination to weigh the children and test their visual acuity.

Equally important are the follow-up examinations of children who have had treatment or are under observation, and the special examination of children referred from a variety of sources, for a particular reason before their next periodic inspection is due. From Table 2 it will be seen that there have been as many follow-up and special inspections as periodic medical inspections during the year and this is to be expected with the increasing emphasis which is being placed on prevention. Nevertheless, although there are wide fluctuations in the number of routine inspections for each quarter of the year in the various Divisions, the total for the year in the Administrative County is practically up to the average which has to be maintained if each child is to be inspected three times in ten years.

3. General Condition of School Children.

Before the Handicapped Pupils and School Health Service Regulations 1945 came into operation it was customary to classify children seen at routine school medical inspections according to their state of nutrition ; a procedure which had been followed since the years when malnutrition was more common than it is nowadays. During the war years the nutrition of school children if anything improved and at the same time it was beginning to be questioned whether a single medical examination of a child gave really reliable information regarding its nutrition. With the more precise definition of nutrition as the process which promotes the growth of the living body and which keeps it in condition, it became clear that as something dynamic it could not be accurately assessed except over a period of time. There was also disagreement as to the best criteria for the assessment of nutrition, and the realisation that nutrition was only one feature in the wider aspect of a child's general wellbeing.

In 1947, therefore, in accordance with the Regulations just referred to and with the introduction of new standard medical record cards, the term ' general condition ' replaced ' nutrition,' and school medical officers were asked to record their impression of a child's general condition in one of three categories : A—good B—fair C—poor.

Further experience has shown that it is equally difficult to assess objectively the general wellbeing of a child, depending as it does upon a variety of things such as its physical state, emotional tension, freedom from infection and that undefinable '*joie de vivre.*' Accordingly, the School Health Service and Handicapped Pupils Regulations 1953 provide for further changes in the school medical record card and the term ' general condition ' has been replaced by ' physical condition.'

However, the school medical officer is still faced with the difficulty that arises from the fact that at an inspection he sees a child for but a fleeting moment of its life, often with little or no reference to its past and certainly with no knowledge of its future ; his findings can therefore be as difficult to interpret correctly as the meaning of a sentence out of context. It is simple to measure a child's growth by weighing and measuring it and it is possible to gauge the stage it has reached in its development, but what one really wants to know is whether the child's rate of growth and progress in development are satisfactory for that child, relative to the individual circumstances of its life and not merely as compared with the mythical average. Only serial examinations can provide the answer to this. It is for this reason that accurate and legible medical records are so important in the School Health Service.

The further reduction to one of two categories ("satisfactory" or "unsatisfactory") into which a school child should be placed according to its physical condition will be welcomed, particularly as the reason for this is a practical one—the circumstances relating to every child whose physical condition is considered unsatisfactory, including his home circumstances, will be thoroughly investigated, so that it can be made as fit as possible. In other words the School Medical Officer is now free to note in individual cases that further investigation is required.

The new medical records will be brought into use progressively as from the beginning of 1956 ; this is therefore the last year in which the A, B and C classification will appear. Allowing for its limitations, and bearing in mind the difficulties associated with the assessment of general condition, it is nevertheless of interest to note the progressive change in the percentage of children classified in the three categories as is shown in the table below.

Classification of General Condition of Pupils

Classification	*Age Group*	1949	1952	1955
		%	%	%
A (Good)	5 years	38.8	51.4	62.1
	10—12 years	39.7	51.9	66.5
	14 years	38.5	50.6	70.1
B (Fair)	5 years	56.7	46.7	37.0
	10—12 years	57.5	46.8	32.9
	14 years	59.5	48.4	29.3
C (Poor)	5 years	3.5	1.9	.9
	10—12 years	2.8	1.3	.6
	14 years	2.0	1.1	.6

It will be noted that the proportion of children of all three ages classified as of good general condition (A) has increased from less than 40% in 1949 to more than 60% in 1955 and that in the case of the 14 year old school children the percentage has been almost doubled. There has been a corresponding decrease in the percentage of children classified as of fair general condition (B) and in 1955 less than 1% of the school population examined were thought to have an unsatisfactory general condition (C).

Whilst many factors have contributed towards this change, not least of which is the higher standard of living in general, few will deny that school meals, school milk, better school buildings and a more enlightened view of the functions of a school have played their part.

4. The Work of the School Nurse.

At the end of 1955, there were 227 full-time School Nurses who were qualified Health Visitors. In addition there were 21 full-time and 23 part-time School Nurses without the Health Visitor Certificate.

The School Nurse has four spheres of work—in the homes, in schools, in clinics, and in co-operation with other social workers.

In the Report of the Chief Medical Officer to the Ministry of Education, 1950 and 1951 home visiting by the School Nurse is discussed :

> " This is the most important duty of the School Nurse. She ought to know her families well and she can only do so if she is the family Health Visitor. She should be personally known to the family doctors so that she may be a link between them, the local health authority's services and the hospitals, just as she is the vital link between the home, the school health service and the school."

The School Nurse visits the homes of children who are excluded from school in order to see that proper care and attention is being given to the amelioration of defects and when necessary, assists parents with advice and instruction given in a discreet and kindly manner. She advises in regard to the precautionary measures necessary to prevent the spread of disease, being careful to ascertain what advice the family doctor has given and ensuring that the treatment ordered is being carried out. Upon instructions given by the Divisional School Medical Officer she makes investigations relating to special cases.

Primarily, every visit to a school by the School Nurse is an opportunity for some kind of health education. Advice to individual children is often appropriate and can be given during the hygiene inspection of scholars which takes place each term. Group teaching is also carried out, and, in addition to these activities, during 1955 courses of lectures were given on " Hygiene and Mothercraft " at two schools in South East Essex, and on " Mothercraft " at a secondary school in South Essex, two secondary schools in Mid-Essex and five schools in Walthamstow. Single lectures on such subjects as " Hygiene and Mothercraft," " Care of the Feet," " Home Safety and First Aid," " The Value of Rest and Relaxation," " Cleanliness and Poliomyelitis," " Cleanliness " and " The Work of the Health Visitor," were given to meetings of scholars, sometimes with their mothers present, and to Parent Teacher Associations in the more rural parts of the County.

Scholars from local schools in a very rural district were invited, just prior to the summer vacation, to attend a demonstration and instruction by an officer of the County Ambulance Service in life saving from drowning which had been arranged by a health visitor for parents attending a Child Welfare Centre. Teachers attended with the children and both they and their charges were very keen to acquire information regarding the latest methods of resuscitation.

A School Nurse authorised by the Divisional School Medical Officer to examine the person or clothing of any child attending school, visits each school as early as possible each term, and in any event within the first two weeks, to undertake a hygiene inspection of each child. All children with defects are followed up by a home visit and this visit is particularly helpful in instances where the School Nurse finds it necessary to advise the exclusion of a child.

There continues to be a steady reduction in the incidence of infestation, and it is of interest to compare the figures for the country with those of the County of Essex during recent years.

Incidence of Infestation per 100 school children

	England and Wales	*Essex*
1950	7.0	3.1
1951	6.0	2.2
1952	5.7	1.6
1953	5.1	1.3

The actual numbers of children found to be infested with vermin at hygiene inspections during 1955 and during the preceding six years are shown in Table 3 (page 67). There was a further drop in 1955 to 1,826 children, and whilst in some districts the limit may have been reached (see Table 4), this is not so for the County as a whole.

Sooner or later, however, despite these figures a hard core will be reached, for, as Dr. John D. Kershaw, Divisional School Medical Officer, North-East Essex, remarks :

> " There will always be a few families which for various reasons fail to keep their children louse-free and infestation will inevitably spread from these children to the children of better-kept families, and some of these latter will be unlucky enough to have lice or nits at the time of inspection."

Apart from the statutory method of dealing with this condition by sending notices every encouragement is given to parents to deal with the nuisance within the family, by instruction, by demonstration and if necessary, by the loan of steel combs for short periods and the supply of hair cream for treatment. Self treatment within the home fosters good relationships and is productive of good results. The proportion of parents requiring statutory notices had dropped to 5% in 1955.

The School Nurse attends the medical inspection at each school in her area and makes a point of conferring with the doctor about difficult cases which are to be seen. She follows up those children in whom defects or problems are found to exist.

At the age of 7 or 8 years (i.e. between the routine medical examination as an entrant and of the 11 year age group) the School Nurse tests the eyes of all children with a view to discovering cases of defective vision which were not apparent at five years of age but which ought to be discovered before a great deal of close study is undertaken.

The School Nurse co-operates with family doctors and social workers, engaged upon statutory and voluntary duties for the promotion of the wellbeing of the family.

B. PROMOTION OF HEALTH

5. Standards of School Premises.

In 1954 new Regulations were made with regard to the standards in school premises. These specify requirements in connection with classroom and playing field space, and sanitary and washing accommodation, according to the size of the school and the number of pupils and they lay down the standards of heating, lighting and ventilation of rooms, and water supply and drainage.

The increase in the number of school children in Essex over the last few years (59,728 since 1949) has necessitated the building of many new schools and conditions in these are excellent. To what extent similar conditions prevail in the older schools and those in the rural areas should be revealed by a survey which is being made. The importance of satisfactory premises in contributing to the maintenance of optimum health should not be underestimated. Poor ventilation, bad sanitation, insufficient daylight, and too close contact between children, unavoidable in overcrowded schools, are the commonest reasons for the spread of infections, and particularly respiratory infections, which are the cause of so much absenteeism.

6. Physical Education.

It is the function of the school to provide for the education of the child as a whole and physical education is an essential part of the school curriculum. Physical training, games (both organised and unorganised) and swimming are the chief activities which constitute physical education. The essence of physical activity is movement and the relationship between this and normal physical and mental growth is explained in a fascinating study prepared by the Ministry of Education (Moving and Growing. Physical Education in the Primary School—H.M.S.O. 6/-).

In reporting on the salient matters of interest in this field during 1955 the Senior Organisers of Physical Education state :

> " During the year, Mr. A. Stokehill, who was Organiser of Physical Education in the Dagenham and Forest Divisions, and in Further Education Institutions, including service of youth, was appointed senior man organiser of Physical Education in Coventry County Borough. This vacancy has not yet been filled.
>
> Lectures, demonstrations and courses in all branches of physical education were, as usual, held at different centres throughout the County, and were very well attended and thoroughly appreciated by the teachers. In addition a one-day course for women teachers of physical education in secondary schools was held at Dagenham County High School. The teachers who attended from all parts of the County, enjoyed and benefited from theoretical and practical sessions in Athletics or National Dancing conducted by well known lecturers, including Mrs. Tyler, the Olympic jumping champion.
>
> A similar one-day course for men teachers in secondary schools was held at the South East Essex Technical College. The subject was ' Circuit Training,' and

the lecturers were Mr. Morgan and Mr. Adamson from Leeds University. Following lectures in the morning, there were practical sessions in the afternoon, and already the benefits of circuit training are being seen in the schools.

During a course for headmasters and headmistresses held at St. Osyth's Training College, demonstrations of gymnastics and national dancing were given, and the high standard of work by the boys and girls was much appreciated. The demonstrations were given by Miss B. M. Rains, senior woman organiser of physical education and Mr. A. Stokehill.

Area Dance Festivals were held throughout the County—they often took place in the open air—and these instructive, enjoyable and colourful sessions were invariably enjoyed by the children and the full gatherings of parents and teachers. It is pleasing to report how well members of Divisional Executives supported these functions.

The plans for the new Primary Schools incorporate fixed climbing and agility apparatus in the school hall. This is another great step forward in the development of the physical education of children in the 5—11 age group."

7. School Meals Service.

I am indebted to the Chief Education Officer for the following report by the Organiser of School Meals Services :—

> "On the selected date in October 1955, over 10,000 more children were taking the school dinner than on the similar date in 1954, a rise of over three per cent. in the proportion of those present. This is the greatest number since the inception of the Service during the War and the highest proportion since the ending of rationing in 1952 and is most encouraging to those concerned with the Service.
>
> Despite rising costs of food and wages, which bring the economic price for the meal to about 1/8¾d., the charge to parents remains 9d. Efforts to raise still higher the standard of the meals and the conditions under which they are prepared and eaten continue. A number of new canteens at existing schools have been approved by the Ministry, who have been able to relax somewhat the ban imposed since 1949 on work of this kind ; and these will be erected as soon as possible. The policy of spending as much as the Ministry will allow for minor improvements (e.g. new sculleries, better ventilation, heating and so on) has continued, and the estimate for this work during the coming year is over £52,000.
>
> It will be remembered that the supply of ⅓ pint of milk daily without charge to each child who wishes for it was transferred from the Ministry of Food to the Committee in October, 1954. The changeover has worked smoothly ; though there has been some unwillingness on the part of the trade to allow discounts, the position is as favourable as that in most counties, and is improving."

High standards of personal hygiene in catering staff and the provision of facilities to encourage this by making them easy and simple to achieve are probably the most important ways of preventing outbreaks of food poisoning in schools. This is constantly impressed upon the staff and it is gratifying to report that no outbreaks of gastro-intestinal infection following the consumption of school meals occurred during the year.

Nevertheless an outbreak of an unusual nature occurred at Barley Lane School, Ilford, in July in regard to which Dr. I. Gordon states that some of the staff and 16 children were known to have been affected by nausea, stomach pain and diarrhoea over a weekend and in some cases of emergency doctors had been called in. Seven only of the persons affected had taken school meals and the possibility of infection from this source was excluded. In the course of investigation it was found that all affected persons had eaten sandwiches, prepared in the school from bread and butter and mustard and cress which had been grown in the classroom. The lint pads on which the cress had been grown were recovered, subjected to laboratory examination and found to be the source of the trouble.

All children from the class affected were followed up and it was found that many of them also had been affected with nausea and diarrhoea over the weekend.

All possible aspects of the outbreak were investigated and it was suggested that the cress was probably infected by a carrier either in the course of growth or at the time of cutting. All water supplies connected with the school were submitted to bacteriological examination, as also were pond waters containing tadpoles and growing weeds—which were in the same classroom—and the faeces from a tortoise in the school playground—with negative results. A further suggestion was that the seed may have been infected in the warehouse, store or shop and some investigations were carried out with regard to this possibility but as the seed was purchased in the previous March, none of it was available locally.

8. Protection of School Children Against Tuberculosis.

As is shown by the following table there has been, since 1948, a striking reduction in the number of school children dying from tuberculosis in England and Wales. The figures for Essex are less spectacular owing to the very small number of such deaths but in 1954 for the first time there were no deaths amongst school children from tuberculosis and the provisional figure for 1955 is two.

Deaths from Tuberculosis

Age Group	*Area*	1949	1950	1951	1952	1953	1954	1955
5—14 years	England and Wales	387	324	274	168	107	66	Not available
	Essex	4	4	3	4	7	—	2
15—24 years	England and Wales	2,596	1,652	1,096	663	441	341	Not available
	Essex		45	24	11	8	12	6

This table also shows that for the age range 15—24 a similar reduction has occurred, the figures for Essex being similar to those for England and Wales. The number of deaths in Essex in this age range has been little more during the last three years than that for the ten years range covering school life.

This is encouraging but it is less satisfactory that for the five years following school leaving age (15—19) the number of notifications of tuberculosis in Essex should rise steeply to three times the number during the last five years of school life (10—14), as is shown in the table below.

Notifications of Tuberculosis in School Children

Age Range	1950	1951	1952	1953	1954	1955
5—9 years	83	65	70	88	53	50
10—14 years	60	57	45	58	45	33
15—19 years	181	160	143	124	132	97

The physical strain of adolescence and its distractions, resulting often in inadequate nutrition and insufficient rest, no doubt contributes to this state of affairs but another factor is undoubtedly the appearance in the adult working community of young people who, as the result of higher living standards, have not acquired an immunity to the disease and their first contact with the infection is therefore at an age when they are particularly susceptible. Modern methods of treatment have dramatically improved the outlook and reduced mortality to a twenty-fifth of what it was eight years ago but the incidence of the disease and its cost in terms of health, working hours and money, are ample justification for continuing every effort to prevent infection.

The School Health Service helps in many ways of which the following are examples :

(a) **School milk.** Of the school milk distributed to schools in the country 98% is either pasteurised or tuberculin tested. In Essex, the milk supplied to schools is pasteurised in every case save one where tuberculin tested milk is supplied. In the great majority of schools the milk is issued in bottles, containing one third of a pint, with straws.

(b) **Tuberculin testing of school entrants.** The aim of this is the detection of active disease among school children and the tracing of active disease among their contacts, especially their family contacts. The procedure as practised in the Forest Division was described fully by Dr. F. G. Brown in the report for 1954. Of the results in 1955 Dr. Brown writes :

> ' It may be recalled that in the Autumn Term, 1954, the technique was changed from that used the previous two terms and the revised technique was the one used throughout 1955. The test was applied

to 1,813 children in the 5—6 years age group, but the results were fruitless ; only two children gave a positive reaction to the Mantoux (skin) test, but both showed no abnormality on being x-rayed. It is, of course, possible that the technique is faulty, but this is not believed to be the cause, as it is exactly the same as that used by some of the Chest Physicians at Chest Clinics in this area.

With regard to the children who gave a positive reaction, only in one case was it possible to trace the source of infection and this was not discovered until March, 1956. The mother was x-rayed in February, 1955, soon after the child was given the skin test, and the film showed a quite limited opacity in the right upper lobe which, at the time of writing this report, had practically cleared. Several attempts were made to persuade the boy's father to have an x-ray examination, but he refused until March, 1956 (one year later) and he appears to be the source of infection, giving evidence of very extensive bilateral acute disease.

In the other case, the child's brother, sister and cousin were x-rayed but all the adults living in the house refused.

The results obtained in 1955 were discussed at a meeting of Chest Physicians and School Medical Officers who have been closely concerned with the scheme, and it is the opinion of the Chest Physicians that, despite the fact that the results revealed little of value, there is room for an investigation of this kind among children of this age group, and it should not be abandoned immediately, although the possibility of continuing it in another form should be considered. I am making some enquiries about this."

(c) **X-ray Examination of School Staffs.** Circular 248 issued by the Ministry of Education in March, 1952, required all teachers entering the service for the first time as qualified or temporary teachers to have an x-ray examination as part of their medical examination. The first teachers for whom the x-ray examination was compulsory were those who left the training colleges in the summer of 1952. The circular also suggested that consideration should be given to the practicability of requiring non-teaching staffs to have a similar examination before entering employment ; and of encouraging school staffs to have an annual x-ray examination of the chest where facilities were available.

Details of the staff of schools who have had x-ray examinations during the year are given in Table 5.

(d) **X-ray Examination of School Leavers.** The x-ray examination of school leavers is carried out wherever possible but is dependent upon the presence in an area of a Mass Radiography Unit. Dr. W. J. Moffat reporting from the South East Essex Division states :

> " During the months of March and April, 1955, the Mass Miniature Radiography Unit attached to Broomfield Hospital, Chelmsford, visited this area and was stationed in turn at Pitsea and Craylands Health Services Clinics and at the Laindon Secondary School. A great deal of publicity was given to this visit and all children over the age of 13 years attending the secondary schools at Wickford, Craylands (Basildon), and Laindon were invited to attend. A total of 665 school children were x-rayed and, although 16 were recalled for a full-size x-ray, only one case was recalled for further investigation and subsequently referred to the chest clinic."

(e) **B.C.G. Vaccination of School Children.** When a child is first infected with tuberculosis his natural resistance may be such that there is no outward evidence of the infection ; alternatively his resistance may be low, or the tubercle bacillus may be of a virulent type resulting in an obvious illness. In either case, when this primary infection heals, the body is left with a measure of sensitivity to the bacillus of tuberculosis ; it is this sensitivity which is made use of in tuberculin tests. The fact that a patient is also left with a degree of acquired resistance, which is of value in preventing reinfection from other sources, led to the introduction of B.C.G. vaccination. The vaccine used for this purpose consists of a weakened strain of the tubercle bacillus and it is used in minute controlled amounts.

B.C.G. vaccination was first offered in Britain as a routine to people likely to be at special risk of exposure to infection and extension of the facility to school children in their fourteenth year followed. In Essex this extension was approved in the Autumn of 1954 and all Divisions made arrangements, which followed a similar pattern in most Divisions, for children to be offered vaccination between their thirteenth and fourteenth birthdays.

In order to acquire the necessary technique for the administration of this vaccine arrangements were made for School Medical Officers to attend special courses at the Great Ormond Street Hospital and they were subsequently approved by the Ministry of Health to undertake this work.

The Heads of Secondary Schools were approached usually at a special meeting before the arrangements were put into operation, the purpose of B.C.G. vaccination was explained and the proposed scheme for each Division discussed with them. Their co-operation has proved to be of the utmost importance, and by and large their interest and full support has been wholehearted.

Talks to parents have taken place in some Divisions but this method of interesting them did not prove particularly successful since few parents attended the special meetings arranged, and they were therefore discontinued. Explanatory leaflets are sent to the parents of children eligible for B.C.G. vaccination from the Divisional School Medical Officer's office with a consent form attached to the bottom of the leaflet so that the leaflet itself could be retained by the parent after forwarding the consent for vaccination through the Head of the school. Many parents discuss the vaccination with the Head Teacher before allowing their children to be vaccinated and it is sometimes possible for the medical officer concerned to talk to a few parents individually when requested. The vaccination of those children in respect of whom consents are received is carried out at the school. The children are asked to attend for a primary tuberculin skin test and three or four days later for this to be read. Those found positive do not require vaccination and only negative reactors are offered vaccination. After vaccination children return in six weeks for a second test to confirm that the vaccine has taken.

The results of the first full year's working of the arrangements for providing B.C.G. vaccination for children in their fourteenth year are as shown in the table on page 24.

A number of interesting points are brought out by this table—

(i) Just over half the number of parents approached agreed to their children being vaccinated, but the proportion varied widely in the Divisions from 17% to 67.6%. (Cols. (b) (c).)

(ii) The percentage of children found to be already positive at preliminary tests was consistently higher in the four rural Divisions than in the urban Divisions, the average for the two groups being respectively 27% and 13.5%. (Col. (e).) In both groups, however, the percentage is considerably less than the 40% found in the urban industrialised communities covered by the Medical Research Council's Tuberculosis Vaccine Clinical Trials.

(iii) All Divisions report almost a 100% vaccination rate amongst the negative children. (Col. (f).)

It is not yet possible to give the reasons for the varying initial acceptance rate and the differences between the incidence of tuberculin positive reactions in individual Divisions, but both these matters are being investigated. It is also anticipated that some details ascertained as a result of the follow-up of the tuberculin positive children will be available later. From the beginning general medical practitioners and chest physicians were informed of the scheme for the vaccination of school children and in some Divisions the positive reactors have been x-rayed and screened at the chest clinic ; in others, however, owing to local circumstances only those with a strong positive reaction could be dealt with.

The Medical Research Council has for a number of years been conducting an investigation into the value of B.C.G. vaccination in school leavers, i.e., children aged 14, and the early experiences of this investigation was one of the factors which led to the extension of the facility to children in their fourteenth year. This investigation is the first controlled trial of the vaccine in Great Britain and one of the striking points about the trial, which is

B.C.G. Vaccination of School Children—1955

Division	*Number of children offered vaccinations* (*a*)	*Number Accepting* (*b*)	*% Acceptance rate* (*c*)	*Positive Reactors at preliminary test*		*Number of children receiving B.C.G. vaccination* (*f*)	*Cases of post-vaccinal complications* (*g*)
				Number (*d*)	*%* (*e*)		
North East Essex	1,405	839	59.7	230	27.4	607	—
Mid Essex	1,838	1,184	64.4	451	38.0	716	1
South East Essex	1,543	518	33.6	108	20.8	398	—
South Essex	1,545	780	50.4	172	22.0	595	23
Forest	1,851	1,144	61.7	169	14.7	956	—
Romford	1,258	500	39.6	69	13.8	407	—
Barking	998	675	67.6	97	14.3	578	—
Dagenham	1,612	788	48.8	100	12.7	661	—
Ilford	872	405	46.4	55	13.5	334	—
Leyton	1,052	187	17.7	25	13.3	162	—
Walthamstow	1,654	857	51.4	109	12.8	728	—
TOTAL	15,628	7,877	50.4	1,585	20.2	6,142*	24

* i.e. 97.7% of negative reactors.

mentioned in the report just published and on which its success depends, is the detailed arrangements made for the follow-up of the children concerned. In this connection Dr. F. G. Brown (Forest Division) writes—

> "Although all the volunteers have now left school and gone their different ways—some with the forces, and others who have married and now have families of their own—contact is still kept with each volunteer and the Health Visitors have made visits to several hundred homes during the past year to obtain information as to the nature of their employment and record details of any illnesses since the date of their last examination. The Physician-in-charge of these trials has expressed his appreciation of the work done on his behalf by the Health Visitors and his satisfaction with the high percentage of response shown by volunteers when called for their annual skin test and x-ray examination."

From this progress report it appears also that amongst school leavers vaccinated the incidence of tuberculosis during the 2½ years following vaccination was only one-fifth of that amongst the unvaccinated school leavers. This evidence of the benefit of B.C.G. vaccination for adolescents would seem to justify every effort to encourage consent to vaccination by the parents of school children in their fourteenth year.

It is hoped that more School Medical Officers will be approved for B.C.G. vaccination in order to facilitate the work, particularly in rural divisions, but it must be borne in mind that there is a considerable amount of clerical work attached to this service which will increase with any increase in the number of children vaccinated ; accurate records are essential.

9. Prevention of Diphtheria.

Table 6 (page 69) gives the number of notifications of diphtheria amongst school children received annually and the number of deaths from the disease since 1949. It also gives the number of school children receiving ' booster ' injections which are given shortly after entry to school as part of the arrangements for diphtheria immunisation.

There have been no deaths amongst school children since 1948, when there were four, but there were 12 notifications in 1955 as compared with one only for each of the three preceding years. On the other hand, the number of children receiving ' booster ' injections is the lowest since 1949. The figures include those immunised by their own doctors. Not all general practitioners claim the fee due to them for notifying the County Council that they have carried out an immunisation ; the actual number of school children immunised, therefore, may be a little higher, but the position is far from satisfactory. There is continual need to maintain a high level of immunisation.

10. Prevention of Foot Defects.

It is not always appreciated how much disability and discomfort arises from deformities of the feet nor the extent to which these occur in the population. A survey carried out a few years ago found that 37% of persons of all ages suffered from defects of the feet ; another sample of old people between the ages of 65 and 70 years, showed that 26.3% of the men and 46.9% of the women were suffering from some foot disability. Even amongst a group of women in the Auxiliary Territorial Service, 96% of whom were under the age of 21, the incidence of foot defects was more than 47%.

Opinions as to the cause of foot defects are not unanimous and certainly there is more than one cause for the various defects that occur. Nevertheless, whilst there is much that we should still like to know about the exact relationship between shoe habits and foot defects, it is widely accepted that unsuitable and improperly fitting shoes and socks during childhood and early adolescent life is one very important factor. In a survey of 1,207 children, 10% had shoes which were too long, whilst 60% had shoes too short.

In order to reduce the incidence of suffering and incapacity among adults, and incidentally the demand for treatment, approval was given in July, 1954, for the appointment of a part-time chiropodist in the South Essex Division with the object of detecting early foot defects in children attending school and advising parents on the buying of properly fitting shoes and socks. The appointment was for a temporary period of six months in the first instance and the chiropodist commenced her duties on the 7th September, 1954.

During the first three months she carried out a complete inspection of the 540 boys at Palmers Boys' School, Grays. During the Christmas holidays, 1954, and the first part of the Spring Term of 1955, she gave individual treatment at Glasson House Health Services Clinic, Grays, to 47 of the boys, who usually attended with their mothers which gave the chiropodist an opportunity of discussing foot hygiene and care. Foot deformities among these secondary school boys were rare but treatment was required for other conditions, e.g., verrucae, athlete's foot and corns. There is no other chiropody service in this district and it took three months to clear these cases and it was not until March, 1955 that the chiropodist was available to visit schools again.

Her sessions have now been re-arranged so that during term time she visits schools and during holidays holds treatment sessions at the clinic. During the last nine months of the year 1955, 3,718 secondary school children were seen, and the children in all save three of the twelve secondary schools in the Division had their feet inspected.

The following observations by a member of the medical staff indicate the usual procedure at a session :—

> "The chiropodist had a class of children at a time and each child came barefooted into the room carrying his shoes. A quick inspection of the feet was carried out for signs of deformities arising from the wearing of unsuitable shoes and for other lesions ; the size of the shoes was checked against the foot. A prefect noted the names and addresses of children requiring treatment."

It is extremely difficult to fix criteria in regard to the need for treatment when the feet of so many of the children show early signs of deformity or other lesions, and some idea of the size of the problem can be gauged from the fact that at least 210 children required treatment ; this is approximately 5.5% of children inspected. Very many more were in need of advice. The chiropodist inspects the feet of approximately 200 children in a three hours session and it is therefore impossible to arrange for parents to be present at the inspection. The number of children for whom advice to the parent is required in regard to the provision of suitable shoes has consequently to be added to the 210 with deformities requiring treatment, and there is a waiting list for appointments at the clinic. The chiropodist has therefore tried to interest the children themselves in the matter of footwear ; she advises them if they are wearing shoes that are too small or otherwise unsuitable and in regard to the kind of shoes they should wear. She has also prepared a leaflet for the child to take home in the hope that the parents will see and read it. Furthermore, as the waiting list for treatment grows the criteria for treatment necessarily becomes more stringent, and only children with marked deformities are advised to attend for treatment.

Details of the work completed in the South Essex Division between September, 1954, and December, 1955, may be summarised as follows :—

Dates	*No. of Schools attended*	*Number of Children*			*Remarks*
		Inspected	*Treated*	*Whose treatment was completed*	
7.9.54 to 22.3.55	1	540	47	47	Foot deformities, rare, mainly verrucae and athletes foot.
22.3.55 to 12.8.55	8	2,034	42	16	101 had anatomical defects. 53 had foot infections.
12.8.55 to 16.12.55	3	1,684	168	—	84 had other conditions (e.g. corns).
TOTAL	12	4,258	257	63	

It will be noted that 28 children had two conditions requiring treatment and that almost 50% of the individual children requiring treatment had an anatomical defect of the feet.

Since this scheme aims at preventing foot deformities in school children in order to prevent incapacity during adult life, it will be appreciated that it is impossible at the end of a year to assess accurately the value of the work done. Approval was given for the extension of the services of the chiropodist for another year from the 1st January, 1956. In the meantime it has still to be shown, firstly, whether the advice given by the chiropodist is followed (it is hoped to obtain information in regard to this by following up a number of children a few weeks after their initial foot inspection to see what action the parents have taken). Secondly, whether this is the best method of using the services of a trained chiropodist. It may be that the examinations and advisory work in schools should be done by School Medical Officers or School Nurses as part of their routine medical inspections but longer-term results are needed, moreover the restrictions on the extension of chiropody services under Section 28 of the National Health Service Act, 1946, must be borne in mind. And thirdly, whether children of a younger age than those attending secondary schools should be included in the scheme.

Dr. Ethel R. Emslie of Leyton (now on the staff of the Leyton Education Division), first showed in 1939 that a high incidence of foot defects can be detected even in toddlers aged 2 to 4 years. Further, one-third of the children seen during a survey at Ilford schools in 1955 had defects. Of this survey Dr. Frances E. O'Connor, a School Medical Officer in the Ilford Division, reports :—

> "One thousand and four hundred children between the ages of 9 and 10 years were examined ; this age group was chosen as a fair average between the infant and senior groups.
>
> Very few children had badly worn or unsatisfactory footwear (0.2%) and few had dirty feet and dirty socks (1.9%). The children were examined in their ordinary outdoor footwear first, then in their bare feet. Not one child had complained of pain in the feet or legs. The thirteen schools visited in the course of the examination covered a wide area of the district so that children from all social levels were surveyed.
>
> Of the total of 1,400 children 468, or about 33%, were found to have foot defects. This is a high percentage and might well be remedied by the development of toddlers' clinics.
>
> A greater number of girls had defects, such as deflection of terminal phalanx of great toe—about 14% of all defects ; whereas boys were only about 9% of this condition. Hallux valgus was more noticeable among girls—34% of all defects compared with about 12% of boys. More girls were suffering from curled toes, probably due to tight shoes worn previously. The incidence of flat feet was equal in both sexes though the number of boys with pes valgus was double that found in the girls.
>
> There were very few defects of the soft tissues considering the large number of children surveyed. A list of all defects is shown in Table 7.
>
> I would like to draw attention to the fact that plimsolls in school, which are a free issue and are chosen by the children themselves, may be badly fitting and crush the feet. Children usually choose shoes too small rather than too large. An adult to supervise and to check sizes periodically—at least once a term—might help to prevent foot troubles or aggravation of existing ones. The same applies to boys' football boots which are put aside when the season is over and worn again the next year and the next—so long as the foot can be squeezed into the boots. Occasionally the boots are passed on to someone else and used though not fitting well. This is the case where the parents cannot afford to buy the boy new boots and his enthusiasm for the game counteracts any pain from tight boots.
>
> Regarding the remedial exercises carried out by the Physiotherapist, where the parents and children co-operate there is rapid and permanent cure of the defect. This is specially so in the treatment of flat feet and pes valgus."

It is particularly interesting to note that in this survey 33% of the children were shown to have foot defects whilst only 0.2% had unsatisfactory footwear.

C. Ascertainment and Treatment

At periodic medical inspections during 1955, apart from those with dental disease or infested with vermin, 15.3% of the pupils were found to require treatment ; this figure compares favourably with that of other parts of the country (e.g. London County Council 14.8%) and is a marked improvement on the position in 1949 when 19% required treatment. Below is given the incidence of certain conditions found to require treatment, per 100 children inspected, for each year since 1949.

	1949	1950	1951	1952	1953	1954	1955
Skin Disease	1.3	1.1	1.4	1.3	1.7	1.6	1.3
Defective vision and squint	4.7	4.2	4.5	4.2	4.6	4.9	4.9
Other eye conditions	.4	.5	.4	.5	.5	.3	.3
Defective hearing	.3	.3	.2	.3	.4	.3	.3
Other ear conditions	.9	.7	.6	.5	.7	.5	.5
Diseases of the nose and throat	3.6	3.8	2.8	2.8	3.1	2.0	1.8
Cervical glands	.2	.3	.2	.3	.3	.2	.2
Defective speech	.4	.3	.3	.4	.5	.4	.4
Conditions of heart circulation	.4	.3	.3	.2	.3	.2	.2
Conditions of lungs	.6	.6	.6	.7	.8	.5	.7
Developmental defects	.3	.3	.4	.6	.5	.4	.4
Orthopaedic defects	5.7	5.6	5.4	5.1	4.8	4.2	3.8
Nervous diseases	.1	.1	.2	.1	.2	.1	.1
Psychological conditions	.2	.2	.3	.4	.4	.3	.3
Other conditions	2.7	2.4	3.0	1.9	2.0	1.8	2.0
Total	21.8	20.7	20.6	19.3	20.8	17.7	17.2

Of the pupils requiring treatment in 1955, 40% were among school entrants and 39% amongst the 10—12 year age group. These proportions are the lowest for the younger group and the highest for the older group during the last six years.

The arrangements for the ascertainment and treatment of each condition are described in detail below.

11. Skin Diseases.

Of the children found to be suffering from a skin disease nearly three-quarters obtain treatment following special examinations, many of them are dealt with at the minor ailment clinics, the remainder being treated by the family doctor.

Children treated for skin disease

Year	*At Minor Ailment Clinic*	*Otherwise*	*Total*
1949	9,093	—	9,093
1950	7,193	191	7,384
1951	6,283	261	6,544
1952	5,445	220	5,665
1953	5,465	512	5,977
1954	4,969	952	5,921
1955	5,294	1,046	6,340

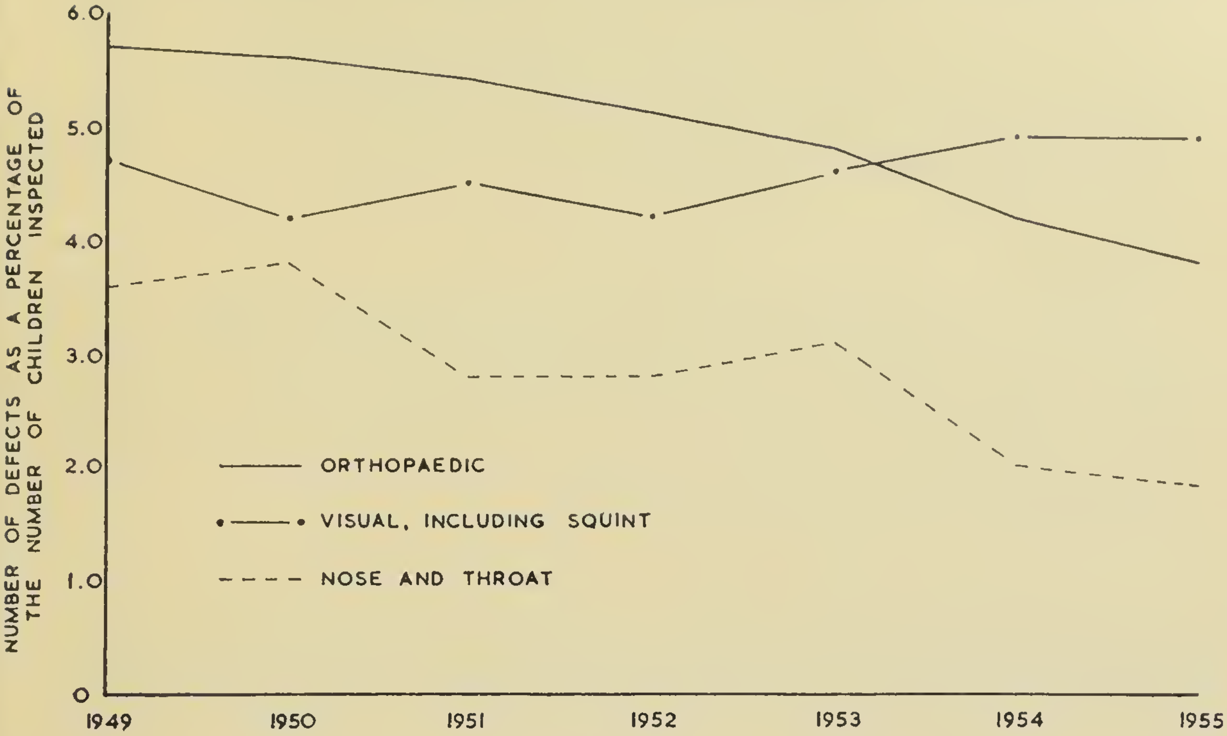
As was to be expected following the introduction of the National Health Service the number of children treated otherwise than at minor ailment clinics has increased ; at the same time the number treated at clinics also shows a steady fall from 1949—1954 but this was not continued in 1955. These changes should not be allowed to obscure the fact that since 1952 there has been an overall increase in the amount of skin disease requiring treatment amongst school children.

It will be seen from Table 8 that Impetigo has been slightly more prevalent in schools during the last two years but that there have been no appreciable changes in the incidence of ringworm and scabies. These three conditions, however, account for less than one-tenth of the skin diseases in school children ; it is the great number of other skin diseases about which we need more information nowadays.

12. Defective Vision.

The graph overleaf shews that in 1954 defects of vision, including squint, became for the first time the chief of the three commonest conditions found at medical inspections to require treatment, not only because of a greater reduction in two other conditions but also because of a higher incidence of defects of vision.

INCIDENCE OF CERTAIN DEFECTS REQUIRING TREATMENT



Omitting cases of squint, three out of every ten children found at medical inspections to require treatment suffer from defects of visual acuity. It is a matter of some concern that, as the following table shows, the incidence of defective vision requiring treatment among 10—12 year old children in 1955 was more than twice that among school entrants.

Age of children requiring treatment for defective vision

Age	*No. of children inspected*	*No. of children requiring treatment for defective vision*	*% incidence*
5 years	28,288	603	2.1
10—12 years	25,153	1,392	5.5

The Ministry of Education has repeatedly urged that a child's vision should be tested as soon as possible after entry to school. In Essex the school nurse carries out this test immediately prior to the first routine medical inspection soon after the child's entry to school at the age of five years. The testing material used includes Snellen test types and, for the illiterates, the " E " chart or picture test cards. The school nurse repeats the test when the child reaches the age of seven or eight years. Children found to have defective vision are referred for special examination by the school doctor before being seen by the ophthalmic specialist.

Ophthalmic specialists sessions, provided by the Regional Hospital Boards, are held in all Divisions. Two extra sessions each week are now provided in the South-East Essex Division and three extra sessions in the Forest Division. When two additional sessions, which are required in the South Essex Division and the three required in the Romford Division, are established the ophthalmic specialist services should be sufficient for the needs of the present school population.

Supply and Repair of Spectacles. Hospital Management Committees are responsible under the terms of the National Health Service (Charges for Appliances) Regulations, 1945, for determining whether the repair or replacement of a school child's spectacles is occasioned by a lack of care on the part of the child. If this is considered to be the case the cost of the repairs is recoverable from the Local Education Authority.

In view of the difficulties which have been encountered from time to time in determining whether the repair or replacement of spectacles could be attributed to carelessness, or otherwise, the Committee approved arrangements whereby Hospital Management Committees pay for the first repair to a school child's spectacles, the cost of the second or subsequent repairs in any period of one year being the responsibility of the Education Committee. By this means it is considered that the total cost of repairs and replacements is equally shared between Hospital Management Committees and the Committee.

Squint. Squint may be cured by wearing suitable spectacles. In many cases this will suffice, but in some, orthoptic training or operative treatment is necessary.

Orthoptic training aims at teaching the child to control his squint and to train his eyes to work together. When the squint is wide and has developed within the first year or two of life, operative treatment is almost always required to straighten the eye.

Mr. H. J. R. Thorne, M.B., B.S., D.O., D.O.M.S., the ophthalmic specialist at the Health Service Clinic at Valentine's Park, Ilford, describes the work of the orthoptist

> "as an indispensable part of a school eye clinic to enable the necessary and full treatment and observations of squint cases (pre- and post-operative) to be satisfactorily carried out."

Some idea of the results obtained by orthoptic training can be gauged from the information supplied from this clinic. In 1955 patients were discharged as follows :—

Orthoptically satisfactory	28
Cosmetically satisfactory	1
Improved	9
Not improved	11
Failure to attend or transferred	16
	65

The report on the work at three clinics in the Forest Division is similar :—

Cured without operation	76
Cured with operation	29
Not improved	15
	120

Reference was made in the report of the Chief Medical Officer to the Ministry of Education for 1952-53 to an increased incidence of squint per 1,000 school children inspected throughout the country, although in some areas the incidence was stationary. The number of children requiring treatment for squint each year since 1949 in Essex is given below. Whilst the incidence rose to a sudden peak in 1953, it fell equally suddenly during the two succeeding years to the lowest level recorded since 1949.

Year	*No. of cases treated*	*Incidence per 1,000 children inspected*
1949	559	.88
1950	564	.85
1951	583	.78
1952	624	.88
1953	834	1.06
1954	604	.78
1955	484	.63

Colour Vision Testing. Some ten years ago the Faculty of Ophthalmologists advised that all children should be tested for colour vision sometime during their school life, preliminarily by Ishihara's plates, those failing this test being re-tested by a lantern test. The term " defective colour vision " is now used instead of " colour blind," as the great majority of people described as colour blind have only a reduced sense of colour appreciation. The defect is usually congenital in origin and is more common amongst men than amongst women, approximately in the proportion of 8% men as compared to 0.4% women.

At present tests for colour vision are carried out in only seven Divisions, usually at the last periodic medical inspection at 14 years, although in Leyton and Dagenham it is done at the intermediate examination of 10-12 years. As there are a number of trades and professions in which accurate discrimination of colour is essential, for reasons of safety or efficiency, it is highly desirable that the presence of defective colour vision should be ascertained, particularly in boys, before the child has begun to think of a career. It is therefore hoped to extend the facility to all Divisions.

13. Diseases of the Ears, Nose, and Throat.

It will be seen from the graph on page 31 that the number of conditions of the nose and throat found at periodic medical inspections to require treatment has steadily declined, and that the level of 1.8 per cent. in 1955 is half the level in 1949. At the same time, throughout this period five children in every hundred have been kept under observation for these conditions. By far the commonest of them is enlargement of the tonsils and adenoids ; the number of children undergoing operative treatment for this has varied widely each year as is shown by the following figures and bears no constant relation to the school population nor to the number of children medically examined each year.

Year	*Number of Children Receiving Operative Treatment for Adenoids and Chronic Tonsils*
1949	1,664
1950	2,371
1951	2,531
1952	1,794
1953	2,677
1954	3,891
1955	2,191

Many factors account for these widely differing numbers, of which one of the most important is the improved health of young children in general ; another is a greater conservatism amongst the medical profession in recommending tonsillectomy. Similar variations are apparent throughout the country and even in adjacent areas of broadly similar type, and in order to clarify the position a special study is to be made by the Ministry of Education which will begin in 1956.

A considerable amount of treatment of minor diseases of the ear, nose and throat is carried out at the clinics, and from these, children are referred, if necessary, to ear, nose and throat specialists. Specialists sessions, arranged by the Regional Hospital Boards, are mainly held in hospitals, but in Barking, Ilford, Leyton and Walthamstow, an ear nose and throat specialist holds sessions in the Health Services Clinic.

Otitis Media. The number of school children with otitis media has continued to fall. In 1949 there were 488 new cases, of whom one in three required operative treatment, but in 1955 there were only 266, and of these only one in five needed operation. Improved general health and modern methods of treatment are responsible for a more rapid and effective cure of this infection, but otitis media is still a serious disease demanding skilled treatment, and it is still one of the main causes of acquired deafness.

14. Treatment at Health Services Clinics.

The treatment of the commoner minor diseases of the skin, eye (excluding errors of refraction and squints), and of the ear constitute a little less than half the work undertaken in the clinics, but the availability of free treatment as part of the National Health Service has affected this to some extent and whilst the treatment of minor conditions continues there is an increasing tendency to use the clinics for special examinations, and for consultations between either parents or teachers and the school medical officer on the varied problems of child health, particularly those which have a direct bearing on the child's life at school. This is a very welcome trend on which Divisional School Medical Officers have commented.

For the first three years following the introduction of the National Health Service, the number of new cases and the total attendances at clinics gradually increased, but since 1951 there has been a steady reduction. Returns made since 1953 indicate clearly a regular fluctuation in attendances, the peak occuring during the winter months of the first and fourth quarters of each year.

The pattern however is not followed in all Divisions, and the overall use made of clinics varies throughout the County. There does not appear to be any marked difference between the rural and the urban Divisions and in the majority of Divisions attendances remain at between 1,000 and 2,000 each quarter ; the average in South Essex being 3,000. In Dagenham attendances almost trebled between 1953 and mid 1955, but have since dropped to an average of 4,000 each quarter, whilst in Barking there are consistently over 4,000 attendances each quarter and sometimes as many as 7,000. This Division has the smallest school population (12,500), and on this basis half the school children attend the clinics. In the remaining Divisions this figure varies from one in seven to one in seventy (Mid-Essex), with a mean of one in twenty.

15. Defect of Hearing—Audiometry.

It will be remembered that Mrs. M. Dodd, the County Audiometrician, commenced duty in May, 1949, and since then reports have been made periodically on her work in the various Divisions. She will be resigning her post early in 1956 and it is therefore a suitable occasion to review the findings of the last seven years.

Since May, 1949, audiometric surveys have been carried out in secondary schools in Walthamstow and Leyton twice, in 1950 and 1956 ; and in those in the Forest, Barking, Dagenham and Ilford Divisions once. A description of the method employed in carrying out these tests with a gramophone audiometer was given in the report of the School Medical Officer for 1949. As has already been mentioned the purpose of the survey is to discover those children with a defect of hearing which is likely to interfere with their normal education, to investigate the cause of the defect and treat it where possible, or where it is not possible, to arrange the special educational treatment consequently needed.

The statistics relating to the seven years period are summarised below; they appear in more detail in Table 9 in Appendix B.

Follow-up of children with hearing loss

Total No. of children tested	74,192
Percentage failing test	2.0%
No. of children seen at Minor Ailment Clinics	1,331
No. then referred to E.N.T. Clinics	549
No. in whom hearing known to be improved or normal after treatment	487

It will be seen that 2% of the primary and secondary school population were found to have some measure of deafness when tested; that nearly half of these children had to be referred to an ear, nose and throat specialist; and that a considerable proportion of them had normal hearing as a result of treatment.

16. Speech Defects.

Speech defects occurred in 0.4% of children examined at routine medical inspections, an incidence which has varied only slightly during the last seven years as will be seen from the Table on page 29. During that period the number of children treated annually by speech therapists increased from 1,546 in 1950 to 2,518 in 1955, which can be only partly explained by the increase in the number of children seen at medical inspections. To meet this increase, the establishment of speech therapists was increased from 18 to 21 early in 1955.

A defect of articulation is the commonest type of defect for which children attend for treatment. Included under this heading are dyslalia (or defective pronunciation of consonants, such as in lisping and lalling, where 'L' is substituted for 'R'), and sigmatism (in which there is defective or excessive use of the letter 'S'), nasal speech (such as occurs in children with cleft palate and nasal obstruction) and dysarthria (in which articulation is imperfect due to in-co-ordination of the muscles of articulation).

Stammering is still usually classified as a speech defect and as the list analysing the work of the speech therapists in Dagenham in Table 11 on page

71 illustrates, is the second commonest condition treated at speech therapy sessions. It is not, however, so much a true defect as a psychological manifestation, the predisposition to which may be inherited and can become an actual stammer as a result of some emotional disturbance.

Speech retardation is quite prominent among speech defects. The age at which children begin to talk varies considerably but when it is delayed beyond the age of three or four years there is often an obvious reason, such as mental defect or deafness. Most children treated for retardation suffer from an emotional disturbance although children who are deaf do occasionally attend the speech therapy clinics. In the treatment of such cases the personality of the therapist and her understanding of children counts most. As in the treatment of stammer there is need for the closest co-operation between the speech therapist and the school medical officer, who should supervise treatment, if necessary, on behalf of the paediatrician or psychiatrist. Where a child has been referred for speech therapy from a Child Guidance Clinic, the speech therapist should attend the case conference. In Walthamstow the speech therapists occupy rooms in the same building as the Child Guidance Clinic.

In most Divisions speech therapy sessions are held in Health Services Clinics. For the benefit of handicapped children requiring speech training a speech therapist attends the Special Schools in Barking and Dagenham. At Ilford a speech therapist has been appointed to the Cerebral Palsy Unit. The speech therapist in Ilford reports on this latter work as follows :—

> " The children at the Unit have been seen to benefit from treatment on the premises, in that they no longer suffer the fatigue of travel before each session, there is no time waste, and they can be seen a little more frequently than was previously possible. The Unit, however, is in its infancy and accommodation for speech therapy is at best inadequate. It has not been possible to provide a room specially for speech therapy so that both therapist and child work under difficulties. It is hoped that in the future a room will be supplied, giving the quiet and familiar atmosphere that is so essential to the cerebral palsied."

Dr. W. T. G. Boul, South Essex, draws attention to the work of the speech therapists in schools—

> " Many visits have been made to schools throughout the year, where the children's progress and reactions are discussed. The teachers' co-operation is always much appreciated as helpful information can be supplied from both sources. Children attended regularly and their parents have co-operated well."

The speech therapists in Ilford in their report also refer to another aspect of their work—

> " We have been interested by the excellent results of the six-year-old experiment in Leicester City where there is a special class for stammerers 'set in an ordinary school, with an ordinary school syllabus, except for daily speech therapy. The children join the rest of the school for art, crafts, music, games and social activities.
>
> Although most teachers are sympathetic and do their best not to put any undue stress on these children from the educational point of view, the competition and natural strains inherent in schooling at all appear to have a particularly bad

> effect on the majority of stammerers. Isolated treatments once a week can do nothing to alter these conditions, but with speech therapy a part of daily school life much could be done. It is interesting and important to note that shortly after entering such a class, where the child is no longer at a gross disadvantage through his speech, there is always a marked improvement in his ability to concentrate and in the school work.
>
> To open such a class in Ilford would certainly not be a simple matter. There would be administrative and transport difficulties, but these could be overcome and we feel sure that results would more than compensate."

In North-East Essex speech therapists work outside their normal period of work for the County Council in the speech therapy department at the Essex County Hospital, Colchester, or at other hospitals in the Group. In referring to this work, Dr. J. D. Kershaw reports—

> "We found this valuable from the County Health Services point of view since it permitted of the following up of former school health service patients and gave us access to the very valuable special equipment which the hospital possesses. The hospital, in their turn, found it most useful."

Four Grundig Tape Recording Machines are now in use in speech therapy sessions. It is hoped to increase the number gradually so that each Division or two combined Divisions will have the full-time use of a machine.

Group Speech Therapy for Pre-School Children. Individual treatment of speech defects is usually considered desirable, especially for severe cases and for older children. For younger children, however, it is not always satisfactory and for this reason towards the end of the year, the speech therapist in the Forest Division commenced group treatment for children with retarded speech aged 3—5 years.

At present the treatment of many of the children under five years who are referred for speech therapy has to be deferred until they are old enough to use much of the usual equipment, this being on the whole too small and intricate for their attainments, although it is hoped by supplying a few items of larger equipment to undertake the treatment of these younger children.

There are two important aspects of this treatment, the first being the improvement of muscle co-ordination generally and in this connection it is the grosser skills which are of most interest to the pre-school child. These include sand and water play, "mothers and fathers," "shops" and constructional play with large bricks. Not only does therapy of this kind give the child a sense of enjoyment (which is so necessary to any form of prolonged speech therapy in young children whose progress depends on holding their active interest), but it permits of an indirect approach to the actual speech therapy which is often the only effective line of approach.

The second aspect is that of group therapy. The kind of play things mentioned above have the advantage that they can be used by small groups of children. Parental anxiety is often at the root of a young child's difficulty with speech. In the pre-school years parents begin to worry about how their child will fare at school, and, surrounded by an atmosphere of tension, the child often begins to build up a resistance which shows itself in a refusal to speak or alternatively to give up the infantile pattern of speech. In such children the speech defect is as much the result as the cause of parental anxiety and the relief of this anxiety is an essential part of treatment. The mere fact of attending a clinic and handing over the problem to someone else is always helpful but whereas a direct approach to treatment requires the building up of a new adult-child relationship, in which the accent is very much on speech training as in the individual treatment method, the group method of treatment more easily allows an indirect approach to be made. Children are happiest and most relaxed and natural when playing amongst themselves, particularly children who are involved in a parent-child conflict, and in a happy and co-operative group of children the accent is taken off speech and the social interplay stimulates in a natural way the normal spontaneous desire to communicate easily and freely by talking.

The extension of speech therapy to children under five is essentially a prophylactic measure, for if these children are allowed to enter school with their speech defect it is always harder to treat the defect because of the invariable worsening of their psychological state.

Unfortunately the attendance of the children selected for group treatment in the Forest Division was poor because of illness and bad weather, and it is therefore not yet possible to report on the results of the treatment.

17. Orthopaedic Defects.

The number of orthopaedic conditions requiring treatment, as will be seen from the graph on page 31, has steadily declined from 5.7 per cent, to 3.8 per cent. of children examined at periodic routine medical inspections. In addition, only 47 per cent. of the children were treated for postural defects and flat feet ; seven years ago 60 per cent. were treated. This again reflects the improvement in general health and well being and the broader concept of education.

Many of the minor orthopaedic conditions do not need to be referred to a specialist ; they can be treated by exercise alone under the supervision of the school medical officer—in fact the greater part of the work of physiotherapy clinics consists in the provision of remedial exercises.

Specialist orthopaedic clinic sessions for school children are held in all Divisions, except in South-East Essex, mostly in Health Services Clinics, but in North-East Essex, Mid-Essex, and Barking, they are held in hospital premises, whilst in Walthamstow there is a session in the open air school. One clinic session in Romford has been transferred from the Health Services Clinic to the Victoria Hospital, and one new clinic session has been provided at Harlow. Additional sessions have been requested for South Essex and Walthamstow.

Physiotherapy sessions are also held in most Divisions in Health Services Clinics, but in Walthamstow a daily session is held at the open air school. It is usually difficult to arrange additional sessions of this description because of the shortage of physiotherapists, but one such session has been arranged in Harlow and additional sessions are proposed for South Essex.

18. Cardiac and Rheumatism Clinics.

During the year a report was issued by a Working Party on Cardiac Problems, set up in 1953 by the British Council for Rehabilitation (1), which drew attention to the fact that there is still much unwarranted invalidism amongst children with abnormal physical signs in the heart. The report made a number of recommendations, several of which were aimed at ensuring the accurate diagnosis of cardiac conditions in school children, the most important being that all children with physical signs in the heart should be referred to a cardiac centre for full investigation. Rheumatic fever and congenital defects are the two important conditions conducive to heart lesions in children.

The present arrangements in Essex are as follows :—

In most Divisions a child is referred by the school medical officer or the general medical practitioner to either a consultant paediatrician or a cardiologist in a nearby hospital. Children from all over Essex attend out-patient sessions at the Oldchurch Hospital, Romford.

In Ilford, a rheumatism clinic is held three times a month and in Walthamstow a similar clinic is held quarterly as required ; both these specialist sessions are held in Health Services Clinics.

Rheumatic fever is not a generally notifiable disease but under the Acute Rheumatism Regulations, 1953, the notification of rheumatic fever, chorea and heart disease is necessary in a number of selected areas, the Borough of Ilford being the only one in Essex. The figures for the notification of rheumatism there confirm the observations made elsewhere that rheumatic fever is far less prevalent than it used to be.

The early diagnosis of congenital disease of the heart has become important because of the advances made in the surgical treatment of these conditions and for this reason alone the rheumatism clinics at present held in the County fulfil a very valuable function.

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(1) Report and Recommendations of a Working Party on the Employment of Patients with Heart Disease (British Council for Rehabilitation).

19. Paediatric Clinics.

In Barking, Ilford and Walthamstow there are arrangements whereby consultant paediatricians hold special sessions in Health Services Clinics for school children and pre-school children once or twice a month. In other Divisions children attend hospital out-patient departments by appointment.

20. Enuresis Clinic.

The enuresis clinic, held weekly at the Public Health Offices at Ilford, continued throughout the year 65 new cases attending ; 52 being referred by Assistant County Medical Officers and four by general medical practitioners. The procedure has remained as described in previous reports but the treatment has been modified a little.

Analysis of the results for 1955 shows that at least 60% of the children became completely dry or showed a marked or very marked improvement. In addition, of the cases referred to the clinic during 1954 and still receiving treatment in 1955, a further 28 were discharged dry, making a total of 60 out of 77 treated.

During the last three years results have shown that if a dramatic response is going to occur with amphetamine sulphate it shows itself by more than one half of the nights becoming dry by the second month of treatment.

The home background is invariably important in the etiology of intractable cases and where it has been possible to alter the environment or circumstances there has often been a corresponding improvement in the child's condition, but there still remain a few cases which in spite of a good home and co-operative parents, have been slow to respond.

It is disappointing that more use has not been made of this clinic by general medical practitioners particularly in view of the results which have been obtained.

21. Psychological Conditions.

The number of psychological conditions found to require treatment at routine periodic medical inspections remains fairly steady at 3 per 1,000, as reference to the Table on page 29 shows. From the returns of treatment (see Table IV in Appendix A) the number of children receiving treatment at Child Guidance Clinics during the last three years was 2,002. During the previous three years the number was 3,181 and there was thus a reduction of one-third at a time when the school population was steadily increasing. From the statistical survey of the work done at Child Guidance Clinics since 1950 (see Table 12 in Appendix B) the number of children referred to the clinics for diagnosis has gradually increased from 739 to 924 which is proportional to the increase in school population. The incidence of children referred was the same in 1955 as it was in 1950, i.e., 3.5 per 1,000.

In view of the increasing amount of mental ill-health, these figures are encouraging so far as they go, but a really accurate assessment of the incidence of behaviour and emotional problems which require attendance at a Child Guidance Clinic is unlikely to be available until the Service is fully developed. In 1955 the first step was taken in the development of the Service in Essex with the opening of a Clinic in Grays to serve the South Essex Division. The Consultant Psychiatrist writes—

> "This Clinic was opened in March, 1955. The premises are situated at Whitehall Cottage, Whitehall Lane, Grays and these are quite adequate.
>
> The staff consists of the Clinic Secretary, who was appointed in March, the Educational Psychologist, who began work in the Division in March, a Child Therapist, who started work on June 7th. There is at present no Psychiatrist and no Psychiatric Social Worker has been appointed. Accordingly it was arranged with the Principal School Medical Officer that a Psychiatrist and Psychiatric Social Worker from Chelmsford should pay visits and do as much work as possible towards providing treatment material for the Therapist.
>
> Ten visits were made by a psychiatrist from Chelmsford and the Psychiatric Social Worker did as much work as was possible in view of her other commitments.
>
> The number of children seen was 33, of whom seven were taken on for treatment by the therapist and 16 were kept under observation.
>
> With the appointment of a Psychiatric Social Worker and a few psychiatric sessions much useful work can be carried out on these premises. However, the work of any Psychiatrist appointed for two sessions will be severely handicapped in the absence of a good Psychiatric Social Worker."

Under present arrangements the Educational Psychologist in addition to interviewing over 400 children has paid 260 home visits and there are now 91 children awaiting diagnosis. It is recognised that there is an urgent need to appoint a Psychiatric Social Worker but there have been no applicants following repeated advertisements.

In the meantime, the four clinics previously established are dealing with children referred to them as best they can, but those in Mid-Essex, Ilford and Walthamstow are each covering a school population at least one and a half times as great as they can adequately serve. The incidence of children referred may not have increased but the number has risen and because the number of children diagnosed has not kept pace, the waiting lists had increased from 281 to 475 by the end of the year.

There were fewer diagnostic examinations at the Mid-Essex clinic owing to staff changes. Dr. J. E. G. Vincenzi, the Psychiatrist, comments :—

> "Psychiatric Social Workers' time has been consistently under strength throughout the year and this has been an important factor in delay in dealing with the large volume of work. The Psychiatric Social Workers in the Clinic have had rooms made available for them at Billericay, Pitsea, Rayleigh, Braintree, Hornchurch and Romford. We now have one full-time P.S.W. and two working four sessions each out of an establishment of two full-time P.S.W.'s.
>
> Psycho-therapy of children diagnosed has of necessity been limited by the

> time available and where other measures have seemed likely to be of benefit these have been carried out.
>
> The Clerical Staff was slightly increased during the year and now consists of one full and two part-time Shorthand Typists and one Clerical Assistant. This is still proving inadequate for the amount of work to be done."

Attention is also drawn to the fact that the number of cases referred from Romford formed nearly half the total.

Intensive efforts were made during the year to find accommodation for a clinic to serve Romford and Dagenham which would relieve the Mid-Essex clinic of almost one-third of the 67,000 school children for which it caters at present.

In reporting on the work of the Ilford Clinic, with a school population of 57,600 in Barking, Dagenham and Ilford, Dr. Susannah Davidson, the Psychiatrist, reports as follows :—

> "The work of the Clinic has continued with little change throughout 1955. Our most pressing problem is the length of our waiting list, which is increasing, with a corresponding delay in seeing children after referral. We are still having a greater number referred to us than we can see during each year, and it does not seem that one Clinic alone can supply the needs of the large area which we serve.
>
> Of the 189 cases referred last year 50 were considered urgent, and in addition we were asked to see and report on 23 cases for the Juvenile Courts. These latter have to be seen without delay and usually involve a greater number of interviews and expenditure of time than other cases, but we welcome this use of our facilities as an important part of community work though it does contribute to the delay in our routine casework.
>
> It has been our policy to give such treatment to every child that we can to obtain a sufficiently good adjustment to maintain mental health in face of the ordinary difficulties of life with which they will have to deal. In practice this means that most children who are taken on for 'treatment' receive weekly psycho-therapy, while their Mothers have weekly interviews to help them in their understanding and handling of the child. In some children the problems are such that less frequent attendances are needed, and we are always looking for methods whereby we can shorten the time of treatment without endangering the success of our work. When the child's problem is mainly one of social adjustment we can sometimes treat them in groups of 5-7 children, and we hope to begin some new groups in the coming year, and as we now have our annexe converted for use as a treatment room we have a suitable room where groups can meet. We are also planning discussion groups for Mothers at the same time.
>
> We have welcomed every opportunity to meet and discuss mutual problems with other workers in allied fields, but pressure of work has prevented us from doing as much as we would have liked. The monthly conferences with the Barking School Medical Officers and Health Visitors have continued and Health Visitors from other areas and Probation Officers have attended conferences on cases in which they were interested. A Psychiatric Social Worker Student came to us for two months in the Summer, and Health Visitor Students spent a day in the Clinic during their training course. Members of our staff have given talks on remedial teaching to teachers, and on child guidance work to the Townswomen's Guild.
>
> Changes of staff have again curtailed our work to some extent during this last year. The sudden death of Miss Harries last Spring was a great loss to the

> Clinic, but happily Mrs. Benjamin came to our rescue temporarily, but was unable to remain with us permanently for family reasons, and we are again one Therapist short. Miss Zaphiriou left us during the year when she returned to Greece, but Miss Barton came to us as P.S.W. in September, and Mrs. Pagram joined our staff of secretaries when the appointment was made permanent. Miss Wicks left us at the end of the year to take up an appointment in a Residential School for E.S.N. Children, in which we wish her every success. We are very glad to welcome Mr. Pickett who is returning to this Clinic as Psychologist in her place at the beginning of February.
>
> We would like to express our appreciation of the great understanding and full co-operation of the Ilford Health and Education Departments, which make an enormous contribution to the increase of our effectiveness in the community."

At the Walthamstow Clinic with a school population of 66,000 including that of the Forest and Leyton Divisions, Dr. Helen Gillespie started an extra session each week as a temporary measure in October in order to work off the waiting list. It was hoped that this could be achieved in six months but after three months,

> "this was discontinued, as in the time at the disposal of the rest of the team we were unable to take on for treatment the extra cases diagnosed, and it is against the policy of the clinic to keep our clients waiting for treatment after a diagnostic interview."

The North-East Essex Clinic is the only one which is really keeping pace with the demands made upon it ; there have been no staff changes and the school population has remained practically the same, i.e., 25,500. Dr. H. N. Davy discusses the importance of children being referred at an early stage :—

> "The ages of the children taken on for treatment and supervision range from extreme infancy up to 18 years in one special instance. 'A stitch in time saves nine' ; by this I mean the earlier the age of referral, the better the outlook for the child and its parents. It can be prophylactic in that the younger siblings of the child referred may also benefit by the advice given. Early referral usually means an economy in the time spent by the Psychiatric Social Worker in her work with the parents, and by the Psychiatrist in treating the child. Even more important, it reflects a greater understanding and co-operation on the part of all Doctors, parents and teachers, who now seek our advice early as this may enable us to prevent major maladjustment in the older child. Advice is sought from Mr. D. F. Ward and myself on cases who never come up for full investigation in the Child Guidance Clinic. The steady decline in the number of delinquent children committed to approved schools by the Courts would seem to confirm that 'prevention' is effective. The early referral of cases is one of the fruits of our preventive work, of our efforts to build up a spirit of co-operation between all those who are responsible in the schools and for 'medico-social work,' if I may use Dr. Kershaw's own phrase.
>
> This preventive work, to which I have referred in my previous reports, has progressed at a steady rate and has taken up a proportion of my leisure time. From the Social Service Forum not only Case Conferences, but smaller study groups have arisen for the purpose of studying the new techniques that have been evolved aiming to prevent family breakdowns, with all the unhappiness that broken homes produce for the children. The Educational Psychologist, Mr. D. F. Ward and

myself have been invited to talk to ' Parent Teachers ' and ' Young Wives' Groups '; and at larger meetings at Chelmsford, Sible Hedingham and Halstead, we were asked to talk about the work of a Social Service Forum. The Social Workers' Group now under the chairmanship of the Juvenile Employment Officer, Dr. Leslie Button, has extended its membership and held regular meetings."

In commenting on this preventive work, Dr. J. D. Kershaw, the Divisional School Medical Officer, writes—

" It should be borne in mind that in this field we are exploring new ground and that though there has been a great deal of learned-sounding talk on the subject in high quarters very few clinics are getting down to practical work. I think that our own efforts will have to continue exploratory and tentative for the time being and we are a long way from the stage at which we can say, for example, what are the functions of a ' Social Service Forum.' At present it is wisest for it to remain more of a ' study group ' than anything else and to concentrate on trying to work out the right practical and theoretical relationships between the various specialists and specialised agencies who are concerned with problems of social health in the individual and the family. Above all things it should avoid creating the impression that it is primarily a child guidance activity ; this misapprehension exists in certain quarters and needs early correction. The ' Forum ' is concerned with problems of ' total health ' and its first aim is to find a balance between the physical, mental, social and spiritual aspects.

The Social Workers' Group has been fortunate in having an aim which is at once more limited and more easily defined, namely the development among the various social workers of an understanding of each other's work. It has already made itself felt in matters of ' field ' collaboration and co-operation, and though it could not have started if there had not already existed the will to co-operate it is turning that rather general quality into something more like an informed purpose."

Work in Ilford on the preventive aspects of mental health is mentioned by Dr. I. Gordon in his report—

" During 1955 a conference with our doctors and nurses and the staff of the Child Guidance Clinic was held with a view to formulating a scheme for closer co-operation between the departments. It was arranged that the appropriate staff would attend conferences at the Child Guidance Clinic dealing with specific cases. Several Health Visitors have indeed attended Case Conferences at the Clinic.

It is hoped that discussions will be held dealing with Mental Health problems with special reference to prevention and its application in Infant Welfare Centres."

In Walthamstow Dr. Helen Gillespie has continued her session for pre-school children.

The Educational Psychologists continue to work part-time in clinics and part-time in schools. Dr. Davidson, the Psychiatrist at the Ilford Clinic, refers to this work—

" Much of the work of our Psychologists is carried out in the schools where problems are discussed and the progress of the children concerned is watched. The co-operation of Head Teachers has been most valuable and many difficulties have been resolved without having to refer the child to the Clinic."

In her report of the School Psychological Service, Miss E. M. Bartlett, B.A., Ph.D., describes this work in more detail—

> " In all, the Committee's staff of nine psychologists have interviewed some 2,600 children, apart from their work in the clinics, the percentage of the school population remaining at about one per cent, as last year.
>
> The work in the schools has taken generally the same form as in previous years. Much of it can most usefully be thought of as a preventive and ' first aid ' mental health service. The psychologists, through their day by day visits to schools, become well-known to the Heads and assistant teachers in their respective areas and can be called on unobtrusively to give advice to teachers and parents on the handling of children's problems, to explain to parents what kind of help they can obtain from the Child Guidance Clinic (thus helping to ensure their co-operation when they attend) and to deal with minor degrees of maladjustment and difficult behaviour before they become more serious.
>
> The psychologists have also continued to help teachers in the formation of remedial teaching groups for both dull children and for those of better intelligence whose work in school has suffered for reasons of health or emotional disturbance. The number of part-time remedial teachers doing this sort of work is increasing as quickly as exigencies of staffing and accommodation allow and some provision of this kind is now available in almost every Division and Borough. Discussion meetings are held from time to time with the remedial teachers and they are all, without exception, keenly interested in the work they are doing. Results continue generally to be extremely gratifying and to justify the relatively small expenditure on the work, particularly as the improvement in the children's school attainments often has a remarkable effect on their stability and adjustment.
>
> Co-operation with other professional colleagues has continued to be very helpful during the year, and the psychologists have again been asked to see children by private practitioners, psychiatrists working for the Regional Hospital Boards, hospital almoners and by officers in the Children's Department. They have again been very appreciative of the co-operation they have received from the staff of the School Health Service. The lecturing programme, both to teachers and to Young Wives' Clubs, Women's Institutes and other bodies has been on much the same lines as in previous years, and the psychologists have also helped again in lecturing for the Home Office, the Ministry of Education and for the University of London.
>
> The County has once more helped in the training of educational psychologists by taking a trainee-psychologist for a month's practical work in the schools and the Child Guidance Clinic in the Mid-Essex Division.
>
> In addition to this work in the normal schools, the psychologists have continued to give their services as required to the children in day and residential special schools. Miss Poulton has carried out a re-assessment of the abilities and attainments of all the boys at Ramsden Hall School who have been 18 months or longer in the school, and has also, in conjunction with the staff and the Youth Employment Service, begun an enquiry into their reaction to employment after they leave. It is hoped shortly to present a report on this."

Visit of German Child Guidance Workers. At the request of the Foreign Office a programme was arranged for one day in September at the Walthamstow Clinic for a group of seven Child Guidance Workers including consultants of clinics and psychologists from Germany.

In the course of the visit Dr. C. L. Casimir briefly reviewed the work being done at Walthamstow referring to the method of referring cases, the history taking, the number of cases admitted and treated weekly, the forms of therapy and the choice of placements available. He stressed their aim which was always to help the child to adjust himself to the family environment and in this respect pointed out how in effect the Child Guidance Clinic was a ' family problem ' Clinic.

The Educational Psychologists then mentioned particular aspects of their work. The visitors were very interested in the problem of children with an average or high I.Q. who were not able to read, a problem which one of them is working on. The Psychiatric Social Workers then added a word on their role in the clinic and a very lively discussion followed.

It was noted from the discussion that in Germany also the Child Guidance Clinics are quite separate from the adult service ; the amount of boarding accommodation for children was moderate but that many clinics had a few in-patient beds attached ; the co-operation between schools and clinics was quite good on the whole although variable ; except for the diagnostic examination, all the clinic work is done in the afternoon.

In the afternoon a visit was paid to Nazeing Park School for maladjusted children. The visitors had all received and read a copy of the report by the Headmaster on the first three years of the school and they all commented upon the clarity of this report and there were not many questions. However, after being shown round the premises and talking to many of the children who were engaged in woodwork, pottery and ' jungle activity ' in the woods there was a further discussion on some of the Headmaster's methods and in regard to a few interesting individual cases.

22. Special Educational Treatment—Handicapped Children.

The statistics relating to handicapped children are summarised in Table 13 of Appendix B. It will be noted that compared with those for 1954 the figures are much the same, except that 54 more children were newly placed in Special Schools and that the number remaining un-placed was reduced from 568 to 459.

When the figures are broken down into the various categories of handicapped children they are much more revealing but in reviewing them it should be borne in mind that it is preferable for a handicapped child who can " hold his own " to be educated in an ordinary school. This follows from the increasing appreciation that a school has a wider function than the provision of academic training and that there are many other activities and features of ordinary school life from which a handicapped child can benefit as much as other children. It is right that the handicapped child should be placed in the normal environment of an ordinary school wherever possible, special educational facilities being provided for them if necessary, in order that this may be done. Not only does this provide them with better training to enable them to fit into a normal community after they leave school but it also allows them to remain at home.

(a) **Blind and Partially Sighted Children.** Blindness is one of the few handicaps which make it necessary for a child to attend a special school. For many of those who are partially sighted, however, the educational opportunities of an ordinary school can now be provided, since recent advances in understanding the defects which cause partial sight have led to a reduction in the restrictions previously placed on the activities of these children and the conditions under which they should be taught. Good lighting and a favourable position in the class are, of course, essential, and as always his level of intelligence, his attainment, and the size of the class, have to be considered before such a child is admitted to a class in an ordinary school.

The number of children ascertained as blind or partially sighted has not materially altered since 1950 ; there were 9 and 13 respectively in 1955.

According to the information available placement of children in both categories is satisfactory. Of five blind children awaiting placement at the end of 1954, four were placed during 1955 ; for the partially sighted the position was much the same, all but one being placed.

There is only one Day Special School for partially sighted children in Essex, at Walthamstow, and the Headmaster reports as follows :—

> " The school re-opened at the beginning of the year at premises in the former Pretoria Avenue School, the girls' section comprising four classrooms, hall, dining room and ancillary service rooms being entirely devoted to the sole needs of the school. This accomodation is much more spacious and provides better teaching facilities than at the Wood Street School, and has the advantage of not being shared with other children. The Committee decided that in future the school should be known as the Joseph J. Clarke School, in commemoration of a former Medical Officer of Health of the Borough.
>
> At the end of the school year there were 43 children on roll. Of these 7 came from Walthamstow, 21 from other Boroughs and Divisions in Essex, comprising Barking, Dagenham, Forest, Ilford, Leyton, Romford and S.E. Essex, and 15 out-County children from the Middlesex Boroughs of Edmonton, Enfield Hornsey, Highgate, Tottenham and Wood Green.
>
> The special ophthalmic sessions held at the school in December showed that the range of visual acuity (Snellen) after correction, was as follows :—
>
> 19 children with acuity of 6/60 or less
> 14 with acuity 6/36
> 5 with acuity 6/24
> 5 with acuity 6/18 or more
> 17 children had monocular vision only.
>
> One child was recommended for transfer to ordinary school, and there is one child awaiting placement in a school for the blind.
>
> As in previous years, the ophthalmic supervision has been well maintained. Dr. I. Gregory, M.B., D.O.M.S., has made two visits to the school for the purpose of examinations, and has given much helpful advice with certain selected cases. The medical staff at the Eye Clinic have also made regular ophthalmic examinations.

> whilst the optician (Mrs. Suckling) has assisted in a speedy supply and repair service of glasses."

(b) **Deaf and Partially Deaf Children.** In contrast to the blind, the increasingly early diagnosis of deafness in very young children, the instruction of parents on how to deal with a deaf child, the provision of hearing aids and instruction in lip reading means that the handicap of deafness is being overcome to the extent that more deaf children are by these means enabled to attend an ordinary school by the time they are five. The main criterion for admission is probably not so much a minimal hearing loss as a measure of intelligible speech and it is for this reason that the earliest diagnosis of deafness is essential. It should be made during the first year of a child's life so that with auditory training the child can become familiar with normal patterns of speech at the time when it normally begins to talk.

Small classes in ordinary schools for seven to eight deaf children, under the guidance of a trained teacher of the deaf, have been tried by a number of Local Authorities and the results have been most promising. Dr. J. D. Kershaw (North-East Essex) draws attention to the changes in the educational requirements of deaf children in his report :—

> " Recent work has shown that the whole problem of the care of the deaf children is very different from what it was a few years ago and that many children with serious hearing defects have enough residual hearing for a hearing aid to be used with advantage at quite an early age. The urgent need here is less for special school education as such than for training in the use of an aid, in speech and in lip reading. Much benefit could be obtained from a teacher of the deaf who would not only teach the children but would advise and instruct parents in their care and management in the home ; the period of waiting for a place in a special school could thus be usefully employed and it is possible that some of these children might thus be enabled to profit by education in an ordinary school."

Since 1951 the number of children newly ascertained as requiring special educational treatment for deafness has decreased steadily. In 1951 there were 23 children and in 1954 and 1955 there were 5 and 8 respectively.

Whilst a two year waiting period to a special school may sometimes occur in some Divisions, placement of these children throughout the County is mainly effected within a year.

During 1955 four deaf and seven partially deaf children who were awaiting placement at the end of 1954 were all placed, as well as one of those newly ascertained during the year, so that only six deaf and two partially deaf children were not placed at the end of the year.

Of the only Day Special School for Deaf Children in Walthamstow, the Headmistress reports :—

> " There was much absence because of illness of all kinds in the Spring. It is the first time there has been anything even approaching an epidemic at this school

but in February the children had measles, chicken pox and gastric trouble of all kinds.

In July Dr. Watkins and Dr. Poole carried out a medical inspection of all the younger children and Dr. Francis Clarke, Ear, Nose and Throat Consultant, examined the children in October.

The entire staff attended a course of lectures in auditory training given at the Old Kent Road School during October. They made us very proud of our wonderful Western Electric Group Hearing Aid—" few London schools have so good a one," but they also depressed us by showing us the utter futility of trying to do really good auditory training without a soundproof room, or even an ordinary room with solid walls. This is one of the few points where there is still room for improvement.

Two partially deaf girls have been sent back to normal schools this year and we are always glad when it is possible to do this. The one who left last year after two years of intensive language and speech training, is preparing to sit the General Entrance Examination to the Grammar School, so in her case the move has been justified. She remains steadily at the top of her class and visits us whenever possible.

At the end of 1955 we had 46 children on the roll, 20 deaf and 26 partially deaf. Five of them live in Walthamstow."

(c) Educationally Sub-Normal Children. Educationally sub-normal children form the largest group of handicapped children in the country, and the same is true of Essex. Nearly half of the 728 children newly ascertained as requiring special educational treatment were educationally sub-normal and at the end of the year three-quarters of those awaiting placement were in this category.

Children who are backward because of an innate limitation of intelligence, especially those with only a slightly lower than normal I.Q., are just as much in need of a normal environment as are more intelligent children, but because of their number the problem of fitting them into an ordinary school is very difficult, particularly in view of the large size of most of the classes.

The number of 299 children ascertained as educationally sub-normal in 1955 is the highest since 1948. During the last seven years only just over a half of educationally sub-normal children have been placed within a year. There has thus been a gradual building up of the waiting list for their placement and at the end of 1955 there were 323 not placed. In the meantime, they are filling the classes in ordinary schools, gaining little for themselves and compromising the education of normal children.

In Essex there are schools for educationally sub-normal children in Colchester, Barking, Dagenham, Leyton and Walthamstow. In addition there are two residential schools for educationally sub-normal children at Ramsden Hall and Hassobury. Unfortunately the latter had to close at the end of the Summer term because of the non-availability of suitable staff. In reporting on the work of the Harrow Green School in Leyton, Dr. M. Watkins writes—

"The Harrow Green E.S.N. School underwent a considerable increase in numbers during 1955. The opening, in September, of Knotts Green Open Air School as a Junior annexe to Harrow Green enabled practically all the children in the Forest Division who had been awaiting admission for some time, to enter school in September. It is satisfactory to be able to give these children the education suitable to their 'age, abilities, and aptitudes.' The older children who have gone to Harrow Green have settled down well and are apparently happy to be there. One boy did not settle well at first as his private doctor seemed to think he was making enough progress in the ordinary school. This boy is, however, correctly placed at present. He may eventually be able to return to a secondary modern school, but he was educationally illiterate when he came, and is making good progress in the special conditions now provided for him.

Since the 1944 Education Act allowed the ascertainment of children suffering from a disability of mind and body at a much earlier age than was possible under the 1921 Education Act, Harrow Green School has provided a 'Nursery Class' for children from five years. It has been found most useful to be able to observe in this class the young child—the 'borderline' case—where it is difficult to decide whether the child is going to be educable or not. The true educationally subnormal child, with no behaviour disorder or physical handicap, can usually take his place in an Infant School for the first year or two, the mental retardation not usually revealing itself clearly until formal education starts in the six-seven year age group. But the child seriously mentally retarded, who is not able to try in an Infant School, can be admitted to the Nursery Class, and it gives the School Medical Officer and the school staff time to make better assessment of the potentialities. Sometimes children are so much helped by the ordered freedom and opportunities of this class, run on Nursery School lines, that they improve and can move out of the 'borderline group' into the educable class. Conversely, of course, children who cannot cope even with this class have to be moved into the Occupation Centre, but at least a truer judgement can then be made when time has been given to those concerned to see how they react.

Children who have no educational ability, but are forced into learning by over-zealous parents, often develop quite serious behaviour problems and are made very unhappy by being asked to do that for which they have no aptitude and will never use in after life. It is a mistaken kindness to put an ineducable child (in the sense of the Education Act) into anything but an Occupation Centre. These children should not be kept too long in E.S.N. schools, and should not come to them at too old an age either. The entry to the Nursery Class at an early age would prevent many of the difficult problems we are faced with at ages 9-10 years. When children have been kept too long in an ordinary school and then the E.S.N. School is asked to take them in at ages when the true educationally subnormal child is beginning to make progress in the 'three R's,' difficulties of placement arise. If they had come at five or six years it would be easier for everyone concerned to come to the correct decision about the child's potentialities. The formation of the Nursery Class has been most useful in this respect.

The 'Junior age group' children are at Knotts Green School, though there is no rigid age limit, ability and mental age being decisive factors. Its very pleasant amenities are much enjoyed by the staff and children, and it is hoped will help them later in their performance too."

Of the facilities for educationally sub-normal children in North-East Essex, Dr. J. D. Kershaw writes :—

"I have commented at length on this subject in previous reports and have nothing new to add this year. I cannot yet feel satisfied with the position at Stockwell Street Special School and I hope that major developments there will

> not be long delayed. The children are happy enough and simple craft training is very successful, but I should like to see more academic achievement among those of the pupils who can expect to profit by teaching in formal school subjects. Problems of accommodation and staffing go hand in hand and the answer is probably to be found in a bigger school, better housed and more fully and appropriately staffed.
>
> A class for retarded children in the coastal area has made a useful contribution to the educational wellbeing of the children there, but, as I have previously indicated, this is not enough. It offers little hope to children with I.Q's between 55 and 70, who are precisely those who have the greatest need. Perhaps the suggestion in my last report, that Clacton children might be brought to an enlarged special school in Colchester, may become a practical possibility in the near future.
>
> We have, in common with other Divisions, felt the closing of the Hassobury Special School very severely. Much though I dislike uprooting E.S.N. children from their homes and sending them to boarding special schools, it has been necessary to do this in a small number of specially difficult cases, where the child's home was so situated as to make travel to and from a day school impracticable or where social and emotional conflicts in the home made it necessary to send the child to a more congenial place if she were to profit by education at all. The hoped-for reopening of the school will be welcome, though it will come too late for the re-admission of a small number of unfortunate girls."

(d) **Mal-adjusted Children.** There is also an upward trend in the number of children who are ascertained as mal-adjusted and who require special educational treatment. The figures were 38 and 40 in 1950 and 1951 and 81 and 65 for the last two years respectively.

All 31 mal-adjusted children awaiting placement at the end of 1954 were placed during 1955, together with nearly half those newly ascertained. There is often a considerable element of urgency in regard to these placements.

The Special Residential School at Nazeing Park has now been open for four years. Towards the end of the year the Headmaster submitted a report on the work covering its first three years. The School is intended to cater for 42 children of junior school age (25 boys and 17 girls) and in the words of the Headmaster :—

> "We are concerned with those children of near average to above average intelligence who for some reason have not made a normal adjustment to the demands of society, and who have reacted to circumstances which they have found intolerable with undesirable, unacceptable and often anti-social behaviour. They are children of normal endowment physically and mentally (a Ministry of Education publication refers aptly to them as 'children of unfulfilled promise'), whose emotional development has been disturbed or impaired in some way.
>
> Most of the children, in spite of average intelligence, have been considerably retarded in school work.
>
> The criteria for selection have been mainly those of age and intelligence. We do not take E.S.N. children, and prefer a near to above average intelligence. We prefer to admit children as young as possible, preferably not older than 9 years. This allows a stay of 2—3 years. In the first place we did take some slightly older children who were in urgent need of placement. Children are referred to the

Education Authority for residential treatment in the first place by the Child Guidance Clinic. Suitable cases for referral to this school are selected by the Special Services section and the County Psychologist, and the opinion of the Headmaster is sought as to whether these children are suitable for admission or for the waiting list for admission. Acceptance or refusal of a child may depend upon the group and problems already in the school e.g., it may not be possible to take a child who is soiling excessively if we have already a considerable group with this symptom, or a very young child needing completely individual attention in all ways if we already have one or two such."

He goes on to describe the aims and methods of the school and says—

"We aim when possible to make a resumption of family life possible, or where there is no home, to restore the child so that he can make a successful relationship with a substitute family. This calls for continual efforts to restore disturbed relationships between parent and child, and to help both to some insight into their difficulties. To this end we encourage parents to write, and to visit as often as possible."

Summing up the experience gained from these three years he reports—

"The need for a vastly improved prophylactic service becomes more and more apparent. Much of the unhappiness and distress which we see in children might have been prevented by more adequate counselling services for parents and adoptive parents. Teachers, particularly infant teachers, health visitors, and all who have contact with young children and families, should receive some more training in recognising the early symptoms of emotional disturbance in children. The earlier these symptoms are recognised, the better the prognosis. Again, many of the children and parents we have dealt with could have been saved much cumulative anxiety and unhappiness had there been guidance available when difficulties began to show themselves. In many cases there need then have been no recourse to residential treatment.

The immediate problem of the best treatment for children who have become seriously maladjusted remains. It is not possible accurately to assess the results of the methods and treatment we offer here. The full measure of our success or failure can indeed only be taken when the children we have treated are themselves adult and responsible for families of their own. Meantime we can see in the children we treat the general lessening of tensions, the loss of the symptoms of unhappiness, the growth of ability to make reasonable relationships, the increase in self confidence and in the will to do things, including class work, and the increase in I.Q. in many cases. We would seem to have greatest success when there is a home to work on and with, even though it may never be a fully satisfactory home. Children who have no homes, or homes which are completely rejecting, present the greatest concern. Hostel placement, with the chance of continuity until school leaving age would be the best arrangement for them but this is often precluded by the severity of their behaviour difficulties which cannot be contained in a day school. Some of us feel that within this school setting we cannot offer these children enough. For such children, the school should remain open throughout the year, to avoid the rejection of holiday placement in children's homes, or foster home. This, apart from other complications, would necessitate increased staff.

There is great need too for a senior school for maladjusted children preferably run in conjunction with this, so that there could be some measure of contact and continuity for those few who need further special placement."

Dr. Helen Gillespie, the Psychiatrist who attends the school, also draws attention to the need for a school for mal-adjusted children over the age of 12. (It is probable that such a school will be open before the end of 1956, at Langham Oaks, near Colchester). With regard to the psychiatric work, Dr. Gillespie reports :

> " 71 children have been admitted since the school opened in 1952, out of which 31 have since left, nine of them leaving in 1955. There are now 40 children on the roll.
>
> **Disposal** : The following is an analysis of the modes of disposal of the 31 children who have left the school :
>
> | | |
> |---|---|
> | To home and day school | 9 |
> | To hostel and day school | 3 |
> | Normal boarding school | 5 |
> | E.S.N. residential school | 3 |
> | Senior school for mal-adjusted | 6 |
> | Declined further residential treatment | 5 |
>
> While it will be seen that a number of those discharged were sufficiently adjusted to be recommended for attendance at ordinary schools, about one third of the pupils were found to be still in need of special residential treatment, since their homes were considered unsuitable to cope with their problems. Everything indicates that this is likely to be a permanent problem for which provision must continue to be made. It is also very satisfactory to know that these children will now be able to be followed through within the County's organisation, thus ensuring continuity of supervision.
>
> It is interesting to note that out of the 71 children admitted 15 were adopted children. Although, of course, a number of children requiring adoption are difficult to handle owing either to their constitution, or the experiences they have undergone prior to their adoption, nevertheless, the high proportion of adopted children among our admissions underlines the great importance of careful selection of adoptive parents.
>
> **Psychiatrist's Work** : This followed the plan adopted previously of discussions with the Headmaster of general problems relating to the children's mental welfare. During the year two additional psychiatric sessions were worked each month, bringing the total up to four per month, and it is now possible to attempt systematic supervision, and some treatment of the more seriously disturbed children. This proves valuable in dealing with their immediate problems of adjustment in a new environment, as well as gaining insight into their deeper emotional problems and trying to help them with these. From time to time various symptoms are reported to me although direct psychiatric treatment is not practicable, I am able to see such children, and make a diagnosis, and discuss matters relating to their handling with the Headmaster.
>
> The school continues to offer a secure and serene background for the children, and one is continuously impressed by their alert and friendly demeanour."

When a child is felt to be in urgent need of individual therapy, arrangements are made for attendance at the Walthamstow Child Guidance Clinic. Because of difficulties in regard to escort only one child attended regularly for play therapy.

(c) **Physically Handicapped Children.** The majority of physically handicapped children are those with cerebral palsy, the second largest category being those suffering from the effects of poliomyelitis.

All 73 of the physically handicapped children needing special educational treatment were placed during 1955 but some difficulty is experienced in placing spastic children. Dr. J. D. Kershaw's experience in North-East Essex is typical :

> " Once again we have had little difficulty in providing adequately for physically handicapped children. Two ' spastic ' children with fairly severe physical disability and substantial mental handicap have been taken into the Wilfred Pickles School of the National Spastic Society which offers long-needed help for children whose dual disability has hitherto not been provided for in any special school. Even this school, however, does not finally solve our problem in respect of spastic children, because in order to be practical it has had to limit its range and is unable to accept the child who is mentally in the borderland between the E.S.N. and the mentally defective. These children remain home-bound and their parents, with the best will in the world, are unable to give them the special care and management which they need. I am impressed by the need for outside contacts for these children and concerned that because they lack those contacts they have no chance of exercising and developing the limited mental powers which they possess. Ideally a boarding special school would probably be best for them ; failing that, a home teacher might help but home teachers willing and able to deal with cases of this kind are anything but easy to find."

A notable event during the year was the opening in May, 1955, of the Cerebral Palsy Unit in Ilford. Dr. D. M. B. Gross, the Medical Officer in Charge, reports as follows :—

> " Nine cases were first transferred from Benton Open Air School and the number was increased to 21 from September by the admission of cases from adjoining districts. The Unit, which has 24 places, is housed in an old Day Nursery and is an annexe of the Open Air School under the same Head Teacher but is otherwise self-contained. In addition to the necessary teaching and domestic staffs there is a Consultant in Physical Medicine who visits weekly, a School Medical Officer who visits weekly and is on call, and ancillary medical staff of physiotherapist, speech and occupational therapists, together with a state registered nurse and welfare workers."

The main criteria for admission to this unit is that the child should be educable. A very wide interpretation of this is used, and it is by no means strictly related to the child's I.Q. If there is any doubt the child is admitted for three months trial. Dr. D. L. Woolf, the Consultant in Physical Medicine sees them all soon after their admission, the mother is always present, together with the Medical Officer in charge, the Headmistress and the Physiotherapist ; the Occupational Therapist and Speech Therapist attend also if necessary. At these conferences the whole plan for the child is conceived and reviewed. There is complete co-operation with general medical practitioners and any specialists who are looking after each child. When children have to attend at hospitals they always take with them a letter explaining that they are attending the Unit and that any physiotherapy or speech therapy which may be considered desirable could be carried out at the Unit. Many of the children have thus been transferred to Dr. Woolf for all their treatment and they no longer attend the hospitals.

The general plan of the unit is to provide suitable children with all necessary education and medical treatment on the spot with the ultimate object that they should become capable of benefitting from education in the Open Air School at Benton Road, Ilford, and eventually be transferred to an ordinary school.

Each child receives physiotherapy for half-an-hour every day and speech therapy if necessary every Wednesday morning. The physiotherapist enlists the co-operation of the mother who attends whilst exercises are being given so that she may know how the child is progressing and receive information as to what exercises she should give the child daily at home. This is a very important aspect of the Unit's work.

The welfare workers are responsible for the general care of the children, which includes unloading them from the school 'bus on arrival, changing them, assisting them in the toilet, helping at meals and preparing them to return home. The main function of the nurse is to give general advice with regard to the health of the children and to teach parents to manage the children at home. She is the main link between the home and the Unit.

Initial difficulties were experienced in connection with lack of space and the transport of the children to and from the Unit ; the facilities for heating during the winter months also gave cause for anxiety and their inadequacy interferred materially with therapy. Nevertheless, much excellent work is being done and much is being achieved.

(f) **Delicate Children.** Many of those children described as delicate have asthma and such children together with the physically handicapped form the majority of children in the Open Air Schools. The placement of these children has occasioned no difficulty ; they usually spend only short periods at the school and figures relating to admissions and discharges for both the Ilford and Grays Open Air Schools show that half of them are fit to return to ordinary schools within a year.

Most of the recently built schools offer similar, if not better, facilities than those found in many Open Air Schools and it is possible that there will be a gradual reduction in the number of delicate children attending such schools. There are Open Air Schools in Grays, Barking, Ilford, Leyton and Walthamstow.

Dr. W. T. G. Boul in reporting on the Open Air School at Grays writes :

> " During the year the usual remedial treatments were continued. These included extra rest, posture and breathing exercises, bar exercises and tipping for those children who were recommended to have them. Almost all the children have

also received regular daily (sometimes twice or thrice daily) issues of such medicaments as were prescribed by the School Medical Officer, viz. Halibut Liver Oil, Maltivite, Malt and Iron, Adexolin, Cod Liver Oil and Malt. They have also received Sulphex nasal drops or cough mixture.

Towards the end of 1954 and during the first half of 1955 the applicants for admission were more than the school could accommodate, so, although children were admitted as soon as places became vacant, until the summer holiday there was a list of children waiting to be admitted. However, an extra teacher was appointed to begin duties in September, so with the formation of the extra class thus made possible all children who were waiting for admission were accepted in September. At the end of the year there were no children waiting admission.

The formation of this extra class, however, was only possible also because the re-building of our burnt out classrooms was completed during the summer holidays. The new building was put into use immediately on returning to school after the holiday, but there was, and is, still not adequate proper accommodation, as the newly formed class had to use a room fitted for temporary use while awaiting re-building, but not a proper classroom at all."

(g) **Epileptic Children.** There have been no difficulties in placing epileptic children during the year and only two out of ten are awaiting placement.

(h) **Children with Speech Defects.** Children with speech defects seldom require special educational treatment since their handicap can be dealt with by speech therapists whilst they attend normal schools. No children were newly ascertained in 1955 as requiring special educational treatment for a speech defect.

REPORT
# of the
PRINCIPAL SCHOOL DENTAL OFFICER
for the year 1955

This is the writer's first annual report in his capacity as Principal School Dental Officer following his taking up duty in June 1955.

At the end of the year under review the number of dental officers in post was 29 whole-time and 46 part-time giving an equivalent of only 42.7 whole-time officers. The effective number is, of course, further reduced as these officers give approximately 10% of their time to treatment in the Maternity and Child Welfare dental services. At the end of the year the school population was nearly 262,000 and under good but not ideal conditions a whole-time dental officer may be expected to cope with the treatment needed from the inspection of 3,000 children. On this basis a staff equivalent to 88 whole-time dental officers would be required in Essex. It was hoped at one time that the service would in fact develop fairly rapidly into a priority one but this has not been so. In fact compared with 1954 nearly 300 treatment sessions less have been devoted to the school dental service.

The pattern of the return of work follows closely that of 1954 allowing for the reduced number of treatment sessions. The number of children seen at periodic inspections is low and efforts are being made to improve this figure. In the light of present staffing conditions great care should be exercised in selecting cases for conservation treatment and generally only those children of parents should be referred who show their appreciation of this type of treatment and who are thought likely to continue to seek it after leaving school. To quote from the Board of Education Circular 1523 (21st August 1940) on the School Medical and Dental Services in war-time—" If there is evidence of persistent neglect of oral hygiene on the part of the child, teeth which are technically saveable should not as a rule be filled. The conservative treatment of such teeth will usually prove ineffective. Any conservative operation with a considerable risk of failure should be avoided by School Dental Officers and consequently few temporary teeth should be regarded as suitable for filling." By thus selecting cases for conservation treatment adequate time may often be given to children with septic or very badly decayed teeth. This planning of treatment will be found to reduce the number of children attending at the clinic for the relief of pain and will allow of less interruptions to treatment sessions generally. It should be remembered that this approach depends on inspections carried out at school so that a considerable proportion of the casual attendances may be anticipated.

The dental service has now the use of 55 premises with 61 surgeries together with a mobile dental unit and the occasional hired premises. Reasonable minimum layout of waiting room, surgery and recovery room in proper sequence is necessary for efficient working and there is no doubt that modern surgery equipment in good premises is important in attracting and keeping dental staff. Improvements in this respect have continued throughout the year.

The dental laboratories at Barking and Walthamstow continue to supply most of the appliances needed in the Service and a few are let out to private technicians. Both the Authority's laboratories are now approved by the National Joint Apprenticeship Committee for training dental apprentices, with staff and facilities for one apprentice at each laboratory.

The incidence of dental decay has risen sharply since the end of the War and much evidence points to the bigger intake of sugar and to the over refining of foods as two of the principal causes. It has been stated that in this country the five year old child starts school with an average of four or five decayed or missing teeth and it must be accepted that the task of righting this state of affairs is far beyond the capacity of the available dental manpower. Preventive measures such as the fluoridation of domestic water supplies to reduce the incidence of dental decay may be the answer. Consideration is being given to this by the Ministry of Health who have stated that the addition of a fluorine salt to the water supply up to a concentration of one part per million will give beneficial results. Pilot schemes are being prepared in some selected areas.

In July 1955 the Ministry of Education Circular 288 and Ministry of Health Circular HM(55)67, regarding orthodontic treatment were received. It is now required that the Regional Hospital Boards should put themselves in a position to undertake a consultant orthodontic service for general dental practitioners and for local authority dental officers and also undertake treatment of the more difficult cases. The matter is at present under discussion with the Regional Hospital Boards concerned to formulate a scheme whereby eventually consultant and specialist attention for Essex children needing orthodontic treatment will be available in all the larger centres of population in the County.

It is now the practice to utilise the services of assistant county medical officers and general medical practitioners for the administration of general anæsthetics for dental extractions thus leaving dental officers more time to devote to the operational side of the service. The successful administration of general anæsthetics to young children often presents problems and it is desirable that persons undertaking this work should be up-to-date both in the techniques and the choice of anæsthetic. Keeping this in mind consideration is being given to arrangements whereby assistant county medical officers may attend refresher courses at regular intervals. By good fortune and arrangement with the North East Metropolitan Regional Hospital Board the services of a consultant anæsthetist on a sessional basis for Walthamstow were secured and it is hoped to extend this service later. By so doing, patients who would otherwise be referred to hospital are treated at the clinic.

During the last few years disquiet has been felt at the lack of recruitment to the dental profession and an Inter-departmental Committee of Enquiry into this was set up during the year under the Chairmanship of Sir Arnold (now Lord) McNair. Its findings are expected in 1956. The Dentist's Bill is on its way through Parliament and its two chief items are that the profession should have its own governing body in the proposed new General Dental Council and that a comprehensive pilot scheme should be put in hand to test the desirability or otherwise of creating a new body of ancillary dental workers. These persons, after a shortened training, would do some of the work which is at present the province of the dentist. It is embodied in the Bill that these ancillary workers would be at first employed only by the National and Local Authority services. It is interesting to read the reference to children's dentistry in the Guillebaud report on the cost of the National Health Service. This Committee is disposed to agree that children's dentistry is a special art and that it can be provided more efficiently and economically in relationship with the Maternity and Child Welfare and School Clinics.

J. BYROM.

APPENDIX A

MEDICAL INSPECTION AND TREATMENT RETURNS

YEAR ENDED 31ST DECEMBER, 1955

Table 1

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING SPECIAL SCHOOLS).

A.—*Periodic Medical Inspections.*

(1) Number of Children examined:—

5 years	28,288
10—12 (plus) years	25,153
14 years	15,245
Total	68,686
(2) Additional Periodic Inspections	7,649
Grand Total	76,335

B.—*Other Inspections.*

Number of Special Inspections	35,641
Number of Re-inspections	40,531
Total	76,172

C.—*Number of Individual Pupils found at Periodic Medical Inspection to Require Treatment (excluding Dental Diseases and Infestation with Vermin).*

Group (1)	For defective vision (excluding squint) (2)	For any of the other conditions recorded in Table IIA (3)	Total individual Pupils (4)
5 years	603	3,684	4,144
10—12 (plus) years	1,392	2,816	3,993
14 years	993	1,256	2,167
Total	2,988	7,756	10,244
Additional Periodic Inspections	351	1,175	1,434
Grand Total	3,339	8,931	11,678

Table II

A.—RETURN OF DEFECTS FOUND BY MEDICAL INSPECTION IN THE YEAR ENDED 31ST DECEMBER, 1955

Defect Code No.	Defect or Disease (1)	PERIODIC INSPECTIONS No. of defects		SPECIAL INSPECTIONS No. of defects	
		Requiring treatment (2)	Requiring to be kept under observation, but not requiring treatment (3)	Requiring treatment (4)	Requiring to be kept under observation, but not requiring treatment (5)
4	Skin	956	950	2,941	98
5	Eyes—				
	(*a*) Vision	3,339	2,602	982	526
	(*b*) Squint	404	397	80	41
	(*c*) Other	255	307	721	88
6	Ears—				
	(*a*) Hearing	226	601	187	69
	(*b*) Otitis Media	151	470	115	45
	(*c*) Other	219	244	294	22
7	Nose or Throat	1,414	4,183	1,083	305
8	Speech	335	505	314	121
9	Cervical Glands	124	1,340	48	54
10	Heart and Circulation	193	754	83	60
11	Lungs	527	1,517	240	171
12	Developmental—				
	(*a*) Hernia	74	228	10	16
	(*b*) Other	212	716	130	54
13	Orthopaedic—				
	(*a*) Posture	665	638	91	129
	(*b*) Flat Foot	1,109	1,131	220	240
	(*c*) Other	1,142	1,854	1,145	276
14	Nervous system—				
	(*a*) Epilepsy	40	110	18	18
	(*b*) Other	72	288	169	88
15	Psychological—				
	(*a*) Development	72	296	118	43
	(*b*) Stability	168	703	166	83
16	Other	1,536	626	5,117	894

B.—CLASSIFICATION OF THE GENERAL CONDITION OF PUPILS INSPECTED DURING THE YEAR IN THE AGE GROUPS

Age Groups Inspected (1)	*Number of Pupils Inspected* (2)	A (*Good*)		B (*Fair*)		C (*Poor*)	
		No. (3)	*% of Col.* (2) (4)	*No.* (5)	*% of Col.* (2) (6)	*No.* (7)	*% of Col.* (2) (8)
5 years	28,288	17,562	62.1	10,463	37.0	263	0.9
10—12 (plus) years	25,153	16,728	66.5	8,286	32.9	139	0.6
14 years	15,245	10,682	70.1	4,471	29.3	92	0.6
Additional Periodic Inspections	7,649	5,065	66.2	2,523	33.0	61	0.8
Total	76,335	50,037	65.5	25,743	33.7	555	0.7

Table III

INFESTATION WITH VERMIN

(1) Total number of examinations in the schools by the school nurses or other authorised persons	567,258
(2) Total number of *individual* pupils found to be infested	1,826
(3) Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	51
(4) Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	6

Table IV

TREATMENT TABLES

Group I.—Diseases of the Skin (excluding Uncleanliness, for which see Table III)

	Number of cases treated or under treatment during the year	
	By the Authority	Otherwise
Ringworm—		
(i) Scalp	16	3
(ii) Body	9	12
Scabies	30	14
Impetigo	378	37
Other skin diseases	4,861	980
Total	5,294	1,046

Group 2.—Eye Diseases, Defective Vision and Squint

	Number of cases dealt with By the Authority	Otherwise
External and other, excluding errors of refraction and squint	1,978	612
Errors of refraction (including squint)	—	17,471
Total	1,978	18,083

Number of pupils for whom spectacles were—		
(*a*) Prescribed	—	10,729
(*b*) Obtained	—	9,523

Group 3.—Diseases and Defects of Ear, Nose and Throat

	Number of cases treated By the Authority	Otherwise
Received operative treatment—		
(*a*) for diseases of the ear	—	54
(*b*) for adenoids and chronic tonsillitis	—	2,191
(*c*) for other nose and throat conditions	—	123
Received other forms of treatment	2,040	969
Total	2,040	3,337

Group 4.—Orthopædic and Postural Defects

	By the Authority	Otherwise
(*a*) Number treated as in-patients in hospitals	249	
(*b*) Number treated otherwise, e.g., in clinics or out-patient departments	—	3,407

Group 5.—Child Guidance Treatment

	Number of cases treated In the Authority's Child Guidance Clinics	Elsewhere
Number of pupils treated at Child Guidance Clinics	724	22

Group 6.—Speech Therapy

	Number of cases treated By the Authority	Otherwise
Number of pupils treated by Speech Therapists	2,486	32

Group 7.—Other Treatment Given

	Number of cases treated By the Authority	Otherwise
(*a*) Miscellaneous minor ailments	11,650	1,154
(*b*) Other—		
Enuresis	140	—
Heart and Rheumatism	—	227
Hernia	—	137
Respiratory diseases	—	223
Digestive diseases	—	281
Injuries	—	267
Other diseases	—	924
Total	11,790	3,213

Table V

DENTAL INSPECTION AND TREATMENT

(1) Number of pupils inspected by the Authority's Dental Officers—	
(*a*) At Periodic Inspections	72,432
(*b*) As Specials	21,622
Total	94,054
(2) Number found to require treatment	60,669
(3) Number offered treatment	59,499
(4) Number actually treated	41,154
(5) Attendances made by pupils for treatment	120,803
(6) Half days devoted to—	
Periodic Inspection	1,160
Treatment	16,195
Total	17,355
(7) Fillings—	
Permanent Teeth	54,630
Temporary Teeth	21,839
Total	76,469

(8) Number of teeth filled—

Permanent Teeth	49,250
Temporary Teeth	20,420
Total	69,670

(9) Extractions—

Permanent Teeth	9,258
Temporary Teeth	43,944
Total	53,202

(10) Administration of general anæsthetics for extraction	21,509

(11) Other operations—

Permanent Teeth	37,959
Temporary Teeth	13,425
Total	*51,384

* including 2,796 operations carried out by oral hygienists.

APPENDIX "B"

Table 1.—School Population

	1954		1955	
	No. of Schools	*No. of Pupils*	*No. of Schools*	*No. of Pupils*
Primary Schools	660	170,578	679	173,542
Secondary Schools	174	81,402	179	88,078
Total School Population		251,980		261,620

Table 2.—Medical Inspections

	1954	1955
1. Periodic Inspections—		
Number of Routine	70,943	68,686
Number of Additional	6,130	7,649
Total	77,073	76,335
2. Other Inspections—		
Number of Special	33,598	35,641
Number of Re-inspections	43,392	40,531
Total	76,980	76,172

Table 3.—Number of children found infested at hygiene inspections

	1949	1950	1951	1952	1953	1954	1955
No. of individual children infested	7,918	6,403	4,902	3,622	3,097	2,535	1,826
No. of cleansing notices issued	1,528	1,229	651	148	53	43	51
No. of cleansing orders issued	46	36	35	34	15	8	6

Table 4.—Incidence of Infestation per 100 School Children

Division	1950	1951	1952	1953
North East Essex	3.9	3.0	2.5	1.2
Mid-Essex	1.3	0.9	0.8	0.8
South East Essex	6.8	5.7	2.2	1.5
South Essex	1.6	1.5	1.3	1.0
Forest	3.6	2.3	2.1	1.5
Romford	1.0	0.8	0.6	1.0
Barking	2.0	1.5	1.1	1.0
Dagenham	4.1	2.1	1.2	1.5
Ilford	1.3	1.1	1.2	0.8
Leyton	5.0	2.9	2.4	2.2
Walthamstow	5.1	4.5	2.5	1.9

Table 5.—X-ray of School Staff

Division	*Number of teachers x-rayed on entering service for the first time*	*Number of teachers who have made use of the facilities provided by Mass Radiography Units*	*Numbers of non-teaching staff who have made use of the facilities provided by Mass Radiography Units*
North East Essex	43	269	124
Mid-Essex	97	146	58
South East Essex	25	44	37
South Essex	41	195	99
Forest	34	157	74
Barking	13	(No information) —	(No information)
Dagenham	24	67	14
Ilford	25	Nil	Nil
Leyton	5	222	110
Romford	116	182	102
Walthamstow	57	57	79
TOTAL	480	1,339	697

Table 6.—Diphtheria

	1948	1949	1950	1951	1952	1953	1954	1955
Notifications	Not known	3	6	5	1	1	1	12
Deaths	4	0	0	0	0	0	0	0
' Booster ' injections	--	10,719	15,555	17,774	17,783	16,045	16,446	13,498

Table 7.—Defects—Ilford Foot Survey

Defect	*Boys*	*Girls*	*Total*
Genu varum	89	53	142
Genu valgum	19	27	46
Deflected terminal phalanx of great toe	18	36	54
Curled toes	33	47	80
Hallux valgus	29	88	117
Flat feet	30	30	60
Ankles Valgus	16	8	24
Dropped transverse arch	1	—	1
Pes cavus	10	—	10
Varus forefoot	11	4	15
Claw toes	2	1	3

Table 8.—Number of children requiring treatment for certain skin diseases

	1949	1950	1951	1952	1953	1954	1955
Ringworm	89	67	135	39	30	46	40
Scabies	160	64	59	37	43	27	44
Impetigo	830	674	365	335	294	326	415
Others	8,014	6,579	5,985	5,254	5,610	5,420	5,839

Table 9.—Summary of Audiometric Surveys

Division	*Total Children Tested* (*a*)	*% Failing test* (*b*)	*Number seen at Minor Ailment Clinic* (*c*)	*Number referred to E.N.T. Specialist* (*d*)	*Number where hearing known to be impaired* (*e*)	*Number found to require hearing aid or lip reading* (*f*)
Walthamstow ...... May 49—Jan. 50	7,851	1.9	121	31	116	2 (new)
Leyton .... Jan.—July 50	7,698	2.1	157	50	75	5 (3 new)
Barking .... Sept. 50—May 51	8,651	2.2	172	83	58	8 (all known)
Dagenham .... May 51—June 52	11,738	2.1	209	116	87	22 (new)
Forest .... June 52—June 53 Oct. 53—March 54	16,817	1.8	297	78	64	7
Ilford .... April—June 54 Sept. 54—Jan 55	12,211	1.3	153	45	24	4 (all known)
Walthamstow ...... Feb.—July 55	9,226	3.1	224	146	63	Not yet known
TOTAL	74,192	2.0%	1,333	549	487	

Table 10. Cause of Deafness in 425 children

Acute or chronic middle ear disease	138
Wax or foreign body in ear	119
Nasal catarrh	110
Enlarged tonsils and adenoids	19
Following infectious disease	11
Nasal obstruction	10
Trauma	6
Congenital	6
Miscellaneous	6

Table 11.—Analysis of work of Speech Therapists in Dagenham

Number of children under treatment in 1954	113
Number of children taken on for treatment in 1955	90
Total	203
Total number of children discharged	92
Number of children discharged with normal or nearly normal speech	61

Analysis of Work	*Number of children*
Dyslalia	71
Stammering	56
Sigmatism	38
Speech retardation	17
Cleft palate	5
Dysarthria	5
Dysphonia	3
Nasal disorders	3
Mutism	1
Deafness	2

Table 12.—Child Guidance Service—Statistical Summary

	North-East Essex *Colchester Clinic*	*Mid-Essex* *Chelmsford Clinic*	*South Essex* *Grays Clinic*	*Ilford Clinic*	*Walthamstow* *Clinic*	Total
Children referred to clinic	146	272	59	189	258	924
Children diagnosed	95	143	33	131	181	583
Children treated or under treatment	116	273	33	68	238	728
Children discharged—						
(a) treatment complete	49	164	1	65	116	395
(b) other reasons	93	239	25	127	158	642
(a) *Psychiatrist*—						
Diagnostic interviews	95	159	32	131	155	572
Treatment interviews	462	634	—	471	680	2,247
Other interviews	876	222	11	102	7	1,218
Average number of Psychiatric sessions per week	5.0	6.0	0.3	7.0	7.0	25.3
(b) *Psychologist*—						
Attendances for testing	98	137	140	95	647	1,117
Treatment interviews	199	305	—	230	370	1,104
Other interviews at clinics	167	18	210	31	92	518
School visits (on behalf of clinic cases)	82	44	237	63	92	518
(c) *School Psychological Service*—						
Individual children seen	294	671	423	295	782	2,465
Children referred to Clinic	15	66	150	41	34	306
(d) *Child Psychotherapist (Non-medical)*—						
Treatment interviews	—	594	10	906	554	2,064
Other interviews	—	154	13	—	—	167
(e) *Psychiatric Social Worker*—						
Treatment interviews	—	805	—	654	1,033	2,492
Other interviews at clinic	870	197	2	7	271	1,347
Home visits	700	473	9	39	57	1,278
Waiting List—						
Children awaiting diagnosis	56	120	91	121	87	475
Children diagnosed awaiting treatment	8	15	—	45	9	77

Table 13.—Summary of Handicapped Pupils

Category	*Newly placed in special schools or homes*	*Newly assessed as needing special educational treatment at special schools or in Boarding Homes*	*Number attending special schools*		*Attending assisted schools*	*Number boarded in homes*	*Number remaining unplaced*
			Day pupils	*Boarding Pupils*			
Blind	4	9	—	46	—	—	10
Partially sighted	13	13	26	33	—	—	9
Deaf	9	8	46	61	7	1	6
Partially deaf	16	9	48	32	6	—	2
Delicate	301	293	237	155	5	9	18
Physically Handicapped	88	76	198	59	16	1	32
Educationally subnormal	215	299	597	234	24	—	323
Maladjusted	61	65	2	90	98	20	37
Epileptic	7	10	—	26	—	—	2
Speech defect	—	—	—	—	—	—	—
	714	782	1,154	736	156	31	439

APPENDIX C

Minor Ailment Clinics

NORTH-EAST ESSEX DIVISION:

School Clinic, Trinity Street, Colchester	Mondays to Fridays p.m.	
Essex County Health Services Clinic, 38 Main Road, Harwich	Tuesdays and Fridays a.m.	
Essex County Health Services Clinic, 15 Head Street, Halstead	Wednesdays a.m.	
Sible Hedingham Secondary School, Sible Hedingham	Thursdays a.m. (during school term).	
Essex County Health Services Clinic, Skelmersdale Road, Clacton-on-Sea	Mondays p.m.	
New Church Schoolroom, Brightlingsea	Wednesdays p.m.	In conjunction with C.W.C.'s
Great Bentley School, Great Bentley	4th Tuesday p.m.	

MID-ESSEX DIVISION:

Essex County Health Services Clinic, Coggeshall Road, Braintree	Tuesdays 10.0 a.m.
Essex County Health Services Clinic, Crouch Road, Burnham-on-Crouch	2nd Monday 10.0 a.m.
Essex County Health Services Clinic, Coval Lane, Chelmsford	Every Monday 9.30 a.m.
Moulsham School, Princes Road, Chelmsford	Thursdays 9.30 a.m.
Essex County Health Services Clinic, Wantz Chase, Maldon	1st, 3rd and 5th Friday 10 a.m.
Congregational Church Hall, Ongar	2nd and 4th Thursday 2.0 p.m.
Essex County Health Services Clinic, 69 High Street, Saffron Walden	Fridays 10.0 a.m.
Central Hall, Stanstead	1st and 3rd Wednesday 2.15 p.m.
Essex County Health Services Clinic, Guithavon Street, Witham	1st and 3rd Thursday 9.30 a.m.
Essex County Health Services Clinic, 58 New Street, Dunmow	2nd, 4th and 5th Monday 10.0 a.m.

SOUTH-EAST ESSEX DIVISION:

Essex County Health Services Clinic, Great Wakering	Fridays a.m.
Essex County Health Services Clinic, Rocheway, Rochford	Tuesdays a.m.
Essex County Health Services Clinic, Eastwood Road, Rayleigh	2nd and 4th Tuesdays 10.45—12.30 p.m. Thursdays a.m.
Essex County Health Services Clinic, Kenneth Road, Thundersley	Tuesdays a.m.
Essex County Health Services Clinic, Nevendon Road, Wickford	Mondays a.m.
Essex County Health Services Clinic, High Road Pitsea	Mondays a.m.
Essex County Health Services Clinic, Florence Road, Laindon	Wednesdays a.m.
Essex County Health Services Clinic, Laindon Road, Billericay	Thursdays a.m.
Essex County Health Services Clinic, Furtherwick Road, Canvey Island	Mondays a.m.
Essex County Health Services Clinic, High Road, South Benfleet	Thursdays 10.45 a.m.
Essex County Health Services Clinic, Timberlog Lane, Basildon	Thursdays a.m.
Essex County Health Services Clinic, London Road, Hadleigh	1st Friday a.m.

SOUTH ESSEX DIVISION:

Essex County Health Services Clinic, 39 Queen's Road, Brentwood	Wednesdays a.m.
Essex County Health Services Clinic, Westland Avenue, Hornchurch	Tuesdays and Thursdays a.m.
Essex County Health Services Clinic, Abbs Cross Lane, Hornchurch	Thursdays a.m.
Essex County Health Services Clinic, 61 Athelstan Road, Harold Wood	2nd and 4th Friday only a.m.
Essex County Health Services Clinic, Upminster Road, Rainham	Thursdays a.m.
Essex County Health Services Clinic, Windmill Hall, Upminster	1st, 3rd and 5th Wednesdays p.m.
Essex County Health Services Clinic, Glasson House, High Street, Grays	Wednesdays a.m.

SOUTH ESSEX DIVISION—*continued.*

Essex County Health Services Clinic, Old Newton Road, Tilbury	Tuesdays and Fridays a.m.
St. Margaret's Hall, Corringham Road, Stanford-le-Hope	Thursdays a.m.
Village Hall, South Ockendon, near Grays	Mondays a.m.
Essex County Health Services Clinic, Stifford Long Lane, Grays	Thursdays a.m.
Essex County Health Services Clinic, Chadwell St. Mary	Tuesdays a.m.
Aveley Health Centre, Darenth Lane, South Ockendon	Fridays a.m.
Essex County Health Services Clinic, South End Road, Rainham	Mondays and Thursdays a.m.
Essex County Health Services Clinic, Hall Road, Aveley	2nd and 4th Fridays a.m.
Essex County Health Services Clinic, London Road, Purfleet	Wednesdays p.m.

FOREST DIVISION:

Essex County Health Services Clinic, Manford Way, Chigwell	Thursdays a.m.
Essex County Health Services Clinic, Hatch Lane, Chingford	1st, 2nd and 4th Monday p.m.
Essex County Health Services Clinic, Marmion Avenue, Chingford	Mondays a.m.
Essex County Health Services Clinic, 15 Regent Road, Epping	Thursdays 1.30—2.30 p.m.
Nuffield House, The Stowe, Harlow	Alternate Fridays.
Essex County Health Services Clinic, Loughton Hall, Rectory Lane, Loughton	Thursdays a.m.
Essex County Health Services Clinic, The Cedars, Sewardstone Road, Waltham Abbey	2nd and 4th Tuesday 9.30—11 a.m.
Essex County Health Services Clinic, 93 High Road, South Woodford	Fridays a.m.

ROMFORD :

Essex County Health Services Clinic, Hulse Avenue, Collier Row	Mondays a.m.
Havering Road School	Thursdays a.m.
Straight Road School	Tuesdays a.m.
Essex County Health Services Clinic, Marks Road	Saturdays a.m.
Harold Hill Health Centre, Gooshays Drive, Harold Hill	Mondays a.m.

BARKING :

Essex County Health Services Clinic, Vicarage Drive, Ripple Road, Barking	Each morning.
Essex County Health Services Clinic, Porters Avenue, Dagenham	Each morning.
Essex County Health Services Clinic, Woodward Road, Dagenham	Each morning.
Essex County Health Services Clinic, Upney Lane, Barking	Each morning.

DAGENHAM :

Five Elms School	Mondays p.m. and Fridays a.m.
Essex County Health Services Clinic, Becontree Avenue	Mondays a.m. and Thursdays p.m.
Fanshawe School	Mondays a.m.
Hunters Hall School	Tuesdays 9.30 a.m.
John Perry School	Tuesdays 11 a.m.
Essex County Health Services Clinic, Ballards Road	Tuesdays p.m.
Essex County Health Services Clinic, Ashton Gardens, Chadwell Heath	Tuesdays a.m.
Essex County Health Services Clinic, Ford Road	Thursdays.
Kings Wood School, Harbourer Road, Hainault	Tuesdays, Mondays 9.30 a.m. 1st and 3rd in month.

ILFORD :

Newbury Hall, Perryman's Farm Road, Newbury Park	Tuesdays and Fridays a.m.
Essex County Health Services Clinic, Goodmayes Lane, Goodmayes	Wednesdays and Fridays a.m.

Leyton :

Essex County Health Services Clinic, Granleigh Road, Leytonstone, E.11	Daily a.m., including Saturdays.
Essex County Health Services Clinic, Leyton Green Road, Leyton	Daily a.m.
Essex County Health Services Clinic, Dawlish Road, Leyton	Daily a.m., including Saturdays.

Walthamstow :

Town Hall	Mondays, Wednesdays, Fridays and Saturdays a.m.
Sidney Burnell School, Handsworth Avenue, Highams Park	Tuesdays a.m.
Essex County Health Services Clinic, Low Hall Lane, Markhouse Road	Mondays and Thursdays a.m.

25 JUL

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